USAID
FROM THE AMERICAN PEOPLE

NICARAGUA HEALTH PROGRAM EVALUATION

April 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by Jack Reynolds and Annette Bongiovanni through the Global Health Technical Assistance Project.

NICARAGUA HEALTH PROGRAM EVALUATION

DISLAIMER
The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

This document (Report No. 08-001-063) is available online. Online documents can be located in the GH Tech Web site library at www.ghtechproject.com/resources/. Documents are also made available through the Development Experience Clearinghouse (www.dec.org). Additional information can be obtained from

The Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
info@ghtechproject.com

This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

ABBREVIATIONS[1]

ADRA	Adventist Development and Relief Agency
AIDS	Acquired immunodeficiency syndrome
AMAS	Health Services Monitoring
ANC	Antenatal care
ART	Antiretroviral therapy
BCC	Behavior change communication
BID	Inter-American Development Bank
CDC	Centers for Disease Control
CRS	Catholic Relief Services
CSHGP	Child Survival and Health Grants Program
DAP	Development assistance program
DCA	Development Credit Authority
DELIVER	Logistics management project
ECMAC	Community Delivery of Contraceptive Methods
EmONC	Emergency Obstetric and Neonatal Care
ENDESA	Nicaraguan Demographic and Health Survey
EOC	Essential obstetric care
FP	Family planning
FUPADE	Rubén Dario Foundation for Human Development
FY	Fiscal year
G-CAP	Guatemala–Central America Program
HCI	Health Care Improvement
HIS	Health information system
HIV	Human immunodeficiency virus
IADB	Inter-American Development Bank
ICAS	Instituto Centroamericano de Salud
IEC	Information, education, and communication
IMCI	Integrated management of childhood illnesses
INSS	Nicaraguan Institute of Social Security
IRH	Institute for Reproductive Health
IUD	Intrauterine device
LMS	Leadership, Management, and Sustainability Project
M&E	Monitoring and evaluation
M&L	Management and Leadership Project
MAIS	Integrated Health Services Model
MCH	Maternal and child health

[1] Note: Italics indicate Spanish abbreviations. Most full names are in English.

MINSA	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental organization
NicaSalud	Network *NicaSalud*
PAHO	Pan American Health Organization
PASMO	Pan American Social Marketing Organization
PCI	Project Concern International
PHI	Pediatric Hospital Improvement collaborative
PMTCT	Prevention of mother-to-child transmission
PROCOSAN	Community Promotion of Health and Nutrition
PROFAMILIA	Association for the Welfare of the Nicaraguan Family
PRONICASS	Nicaraguan Social Sector Reform Support Program
PSI	Population Services International
PSIC	FamiSalud Integrated Community Health Project
QAP	Quality Assurance Project
RAAN	Northern Atlantic Autonomous Region
RAAS	Southern Atlantic Autonomous Region
RH	Reproductive health
RTI	Research Triangle Institute
SCF	Save the Children Foundation
SILAIS	Local Integrated Health Service Systems
SINAR	Childhood Information System and Adolescence in Risk
SIVIN	Integrated Nutritional Surveillance System
SOW	Scope of work
STI	Sexually transmitted infections
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

USAID/Nicaragua requested that the Global Health Technical Assistance Project conduct an evaluation of its health program, which includes activities funded by the Child Survival and Health Account. There are four objectives: (1) assess project effectiveness; (2) identify factors that affect effectiveness; (3) identify approaches and materials to scale up; and (4) identify strategic priorities for future support.

The results of this evaluation will be used to provide the basis for USAID/Nicaragua to determine future maternal and child health (MCH) program priorities. Because the Family Planning Graduation Plan for USAID/Nicaragua (currently in draft) provides the assessment and recommended priorities for family planning (FP), this evaluation will not encompass FP except by reference.

MATERNAL AND CHILD CARE

Health Status. The health program of the Government of Nicaragua has produced many successes over the past two decades. Childhood immunization coverage has consistently been the stronghold; 85 percent of children have received all their vaccines. Another laudable achievement is that 70 percent of women of reproductive age are using modern contraception, a rate comparable to that of the United States (73 percent). The great push to institutionalize labor and delivery has paid off: 74 percent of all deliveries now occur in health facilities and are assisted by a skilled provider. Infant mortality has been halved since 1992/93, dropping from 58/1,000 live births to the current 29/1,000 live births.

However, distinct challenges remain. Newborn mortality has barely changed in 10 years—17/1,000 live births in 1997/98; 16/1,000 live births in 2006/07—and comprises 55 percent of all deaths of children less than a year old. Maternal mortality is also clearly a major concern, especially in the Northern Atlantic region. Malnutrition rates, while on a downward trend, remain quite high; close to one in five (17 percent) of all children is chronically malnourished.

Most troubling, despite the triumphs and positive trends, is the inequity between rich and poor. With few exceptions, the national averages mask wide disparities among socioeconomic quintiles. For example, only 42 percent of the poorest pregnant women have a skilled attendant with them when they give birth.

Interventions The projects that USAID/Nicaragua supports are primarily focused at the community and secondary levels of care. The primary level of care is involved only insofar as it relates to the other two levels. System strengthening is an important component of the MCH effort that has immediate implications for all health programs. There are four main implementing partners:

- **PRONICASS,** the Nicaraguan Social Sector Reform Support Program, is responsible for systems strengthening. The main building blocks of this project are decentralization of health services, results-based budgeting, community mapping, a comprehensive pharmaceutical logistics system, and community participation.

- **FamiSalud,** a coalition of 28 nongovernmental organizations, facilitates implementation of Government of Nicaragua community-based programs. These feature:
  - *PROCOSAN*, a program to reduce child malnutrition;
  - *Plan de Parto*, which helps expectant families to form a viable plan to secure facility-based births;
  - *ECMAC* (Community Delivery of Contraceptive Methods), in which community volunteers promote and provide contraceptive methods to populations that have limited access to the formal health sector; and
  - *Agua Segura*, a safe water and sanitation program.
- **Health Care Improvement (HCI**) works in hospitals on quality improvement in essential obstetric and newborn care. Its goal is to improve case management of labor, delivery, and postpartum complications and care of severely ill children under five.
- **Alliances** fosters MCH innovations by mobilizing private sector contributions on a 2:1 private/public match.

Achievements. The leadership participants supported by PRONICASS were given a real issue to resolve: how to harmonize the National Health Plan and the Service Delivery Model. Substantive long-term support so far has been limited to development of a health care model and institutional reorganization. FamiSalud has been training volunteers, disseminating materials, and providing oversight of community programs in 12 departments. It is also building subnetworks to transfer knowledge and experiences among its member NGOs. HCI's work has produced remarkable advances in the management of maternal and newborn hospital care in all departments except Managua, where it is not active. Trained hospital staff now monitor their own quality and outcome indicators, using the results to create ways to solve problems. As a result, there has been impressive improvement in maternal and newborn mortality and morbidity rates.

Problems and Gaps. Even though USAID/Nicaragua's MCH investments have produced admirable achievements, at scale and with a nominal budget, much remains to be done. The new Government of Nicaragua, which is in a state of flux, is increasingly demanding a stronger health sector. Among its priorities are (a) finalizing the health information system; (b) reinforcing municipal health councils; (c) reorganizing the internal administration of the Ministry of Health (MINSA); and (d) drafting an operational plan for implementing the Government of Nicaragua's conceptual model for integrated care. USAID/Nicaragua should review needs in primary care to smooth the "critical route" to care.

The linkages between the community and hospitals should be strengthened. Maternal nutrition and immediate postpartum care are not being adequately addressed. Giving more attention to filling these gaps and more support to maternity waiting homes will help fortify linkages between the community and the formal health system. Lastly, although it is important to use private/public partnerships as a springboard for innovations, the door is too wide open: A lack of technical health capacity has compromised the selection of alliances that would have the best strategic fit with USAID/Nicaragua's overarching MCH strategy.

HIV/AIDS

Health Status. HIV prevalence in the general population is less than one percent, but it is higher among high-risk groups: nine percent in men who have sex with men and more than one percent in female sex workers. Incidence figures from MINSA show a sharp increase in the number of new cases of HIV and AIDS; the figures went from 2.5 percent in 2000 to 7.7 percent in 2005 to 12 percent in 2007. The most common form of transmission was sex (94 percent); perinatal transmission was only four percent. The epidemic is thus concentrated in high-risk groups, largely female sex workers and men who have sex with men in urban areas along the northwest corridor, the frontiers, and the coastal areas.

Interventions. USAID-supported interventions have concentrated on preventing the spread of the disease. Of the two most cost-effective interventions, free distribution of condoms is now covered by MINSA and social marketing of condoms by PASMO (the Pan American Social Marketing Organization).[2] The next three most cost-effective interventions are where USAID funds are concentrated: behavior change communication (BCC) for high-risk groups; voluntary counseling and testing (VCT); and BCC for indigenous males. USAID supported only one of the less cost-effective interventions, prevention of mother-to-child transmission (PMTCT), which was selected as a way to get a foot in the door with respect to convincing MINSA to invest more heavily in preventing infections among high-risk groups.

Achievements. The work done by HCI and PSI[3]/PASMO has been exemplary—and very much in line with MINSA objectives. At MINSA's request, HCI developed a PMTCT model. By the end of 2007 some 76 percent of hospitals that provide MCH services and 49 percent of health centers in Nicaragua were covered; testing of pregnant women increased to 71 percent in these facilities. HCI also developed and implemented a hospital training program to reduce stigma.

PSI/PASMO, which concentrated on BCC among high-risk men and women, contacted 180,733 people in FY 2007. Bilateral support enabled PSI/PASMO to open five new sites in border and coastal areas where high-risk female sex workers and men who have sex with men are found.

Problems and Gaps. Nevertheless, there are significant problems and gaps in the current program. There is a great need for data on prevalence for planning and evaluation. Without this information neither MINSA nor USAID can determine where to concentrate interventions and how well they are working.

MINSA, which has as a major objective to reduce the spread of HIV/AIDS among high-risk groups, is concentrating more on treatment—antiretroviral therapy (ART), PMTCT, and co-infections (HIV-TB)—than on prevention and education.

---

[2] MINSA has also taken responsibility for rapid test kits and purchased some 80,000 kits for use in 2008.

[3] PSI = Population Services International.

TABLE OF CONTENTS

TABLES

FIGURES

1. INTRODUCTION

USAID/Nicaragua requested that the Global Health Technical Assistance Project evaluate its health program, which includes activities funded by the Child Survival and Health Account. The results of this evaluation will be used as the basis for USAID/Nicaragua to determine future maternal and child health (MCH) program priorities. Because the Family Planning Graduation Plan for USAID/Nicaragua (currently in draft) provides the assessment and recommended priorities for family planning (FP), this evaluation will not encompass FP except by reference.

1.1 PURPOSE OF THE EVALUATION[4]

The objectives of this evaluation are to

1. Determine the effectiveness of the current health approach and the outcomes achieved;
2. Identify factors that had a positive or negative impact on effectiveness;[5]
3. Identify approaches and materials that should be finalized or disseminated for the benefit of USAID/Nicaragua-supported efforts; and
4. Identify strategic priorities for USAID/Nicaragua's future MCH support.

1.2 BACKGROUND

USAID has provided health assistance since it returned to Nicaragua in 1991. The current agreement for 2003–08 includes assistance to the Government of Nicaragua, the private sector, and numerous local nongovernmental organizations (NGOs) to improve MCH. There are two program elements: "increased and improved social sector investments and transparency," and "improved integrated management of child and reproductive health." The latter covers HIV/AIDS.

1.3 HEALTH STATUS

1.3.1 Maternal and Child Health

Since 1992 Nicaragua's reproductive, maternal, and child health indicators have been on a positive trajectory. FP advances have been so impressive that USAID will be closing out its FP program in the next few years. The immunization program has also been a long-term success. Table 1 summarizes impact indicators reflecting contributions from USAID's health portfolio over a 15-year time period (see also Annex D for current MCH indicators by Local Integrated Health Service Systems [SILAIS]).

Other donors also have significant MCH portfolios, including the Pan American Health Organization (PAHO), the Inter-American Development

[4] See Annex A for the complete statement of work.

[5] Suggested by the evaluation team and approved by USAID/Nicaragua.

Bank (IADB), UNICEF, UNFPA, the World Bank, and the Embassy of the Netherlands. The IADB has granted the Government of Nicaragua a $30 million "performance-driven" loan (2005–10) to reduce mortality due to maternal hemorrhage and neonatal asphyxia through promotion of births in institutions. A new $20 million loan now being considered will be designed to strengthen referral and health information systems (HIS) and hospital infrastructure in Jinotega, Matagalpa, and the North Atlantic Autonomous Region (RAAN).

Table 1: Trends in MCH Indicators

Indicator	1992/93	2006/07
Total fertility rate	4.6	2.7
Modern contraceptive prevalence rate	45%	70%
Neonatal mortality rate (per 1,000 live births)	20	16
Infant mortality rate	58%	29%
Births in facilities	59%	74%
Chronic malnutrition	25% (1997/98)	17%
Total immunization Rate	80% (1997/98)	85%

Source: ENDESA.

Despite the infusion of donor funds, there are considerable MCH challenges, especially for maternal and neonatal health. Many babies are dying waiting in the emergency room of hospitals. There are only two functioning neonatal intensive care units in the entire country. The national average of 74 percent of births in facilities masks the fact that in the poorest quintile of pregnant women, only 42 percent have a skilled attendant during delivery. Similarly, the national malnutrition average of 17 percent hides the degree of malnutrition in five of the poorest departments: More than a quarter (27 percent) of all children in Jinotega, Madriz, Nueva Segovia, Matagalpa, and RAAN are chronically malnourished. Maternal and neonatal health and nutrition are the key health problems facing Nicaragua today.

1.3.2 HIV/AIDS

Table 2: HIV/AIDS Cases, 2007

Distribution	Number	Percent
Cases	3,122	100.0
HIV	1,969	63.1
AIDS	425	13.6
Deaths	679	21.7
Incomplete data	49	2.0

Data from the 2007 HIV/AIDS/STI Surveillance Report[6] show 3,122 cases of HIV/AIDS in 2007. In 1992 only 34 cases were reported, in 2000 127, and in 2003 226. In 2007 the HIV incidence rate reached 12 per 100,000, up from 7.64 in 2006. This increase is thought to reflect much better recording and reporting now that rapid testing and voluntary counseling and testing (VCT) have been expanded to almost all SILAIS.[7]

The HIV/AIDS prevalence rate was highest in Chinandega (22.3), Managua (21.5), and the Southern Atlantic Autonomous Region (*RAAS*) (19.4), and lowest in Matagalpa (1.1), Jinotega (1.5), and Madriz (2.1). This demonstrates the concentration of cases along the more populated western corridor. Overall prevalence was 4.3 per

[6] *Vigilancia de ITS/VIH/SIDA*, MINSA PowerPoint slide, undated.

[7] SILAIS = Local Integrated Health Service System.

100,000, 87 percent of which were in the 15–44 age group. The major method of infection was sexual (94 percent); only four percent was from perinatal infection.

The Nicaraguan Demographic and Health Survey (ENDESA) did not report on incidence and prevalence but did show that 98 percent of women aged 15–49 had heard of AIDS and 97 percent knew of at least one way to avoid HIV infection. As one would expect, knowledge was higher among the more educated and those living in urban areas. USAID asked the evaluation team to provide a breakdown for 15–19 year olds, but those data are not available.

Thus, the epidemic is still concentrated among high-risk groups, in particular female sex workers and men who have sex with men in the more densely populated western corridor.

1.4 METHODOLOGY

The two-person evaluation team met with GH Tech Project staff in Washington, D.C., to develop a plan for the evaluation, which was sent to USAID/Nicaragua for review and approval. Interview guides were developed for MCH and HIV/AIDS. The team then traveled to Nicaragua, where it spent five weeks reviewing documents and interviewing key personnel in the government, USAID, NGOs, and the private sector. The team also made visits to SILAIS, hospitals, health centers, health posts and community activities in Estelí, Chinandega, Matagalpa, RAAN, León, and Managua. These visits included interviews with a range of informants, from hospital officials and health center providers to community beneficiaries. The team had a mid-term review and two debriefings with USAID/Nicaragua before leaving Nicaragua. A draft of this report was given to USAID/Nicaragua before the team left Nicaragua and, in response to their comments, finalized and submitted to GH Tech for editing and formal submission to USAID/Nicaragua.

Table 3: USAID Partners and Interventions

USAID Partner	Interventions
Maternal & Child Health	
HCI	Quality assurance of MCH service delivery
PRONICASS	System strengthening
FamiSalud	Community-based MCH, safe water, NGO network strengthening
Alliances	Public-private partnerships to develop innovations
Other	Community-based MCH, safe water, food rations
HIV/AIDS Prevention	
HCI	PMTCT, stigma, VCT
PSI/PASMO	Behavior change
Capacity	Hospital quality
Other	IRH (quality VCT)

1.5 USAID PARTNERS AND KEY INTERVENTIONS

The findings fall into two major categories:

- MCH interventions of HCI (formally known as the Quality Assurance Project, QAP), PRONICASS, FamiSalud, and Alliances
- HIV/AIDS interventions of HCI, PSI/PASMO, Capacity, and the Institute for Reproductive Health (IRH)

Although these are all USAID-supported agencies, each has its own scope of work and funding sources. Thus, although their work has often been collaborative, they are not contractually connected.

2. MATERNAL AND CHILD HEALTH

2.1 EFFECTIVENESS

The USAID MCH portfolio is clearly in accordance with MINSA's priorities as confirmed by all donors and the MINSA staff interviewed. According to the Conceptual Model for Integrated Health Services (MAIS), MINSA heavily emphasizes quality assurance and integration of services. The previous administration was more focused on hospital-based care, and while its current thrust is toward a community-centered perspective, MINSA has not yet been able to achieve a strong presence beyond its health posts. Nevertheless, MINSA staff appreciate external assistance at the community level and are actively collaborating with staff of USAID-funded projects. The USAID portfolio is also a good complement to the other international donor programs implemented by the Pan American Health Organization (PAHO), the IADB, the UN Population Fund (UNFPA), UNICEF, and the World Bank. USAID's participatory approach has reduced duplication of efforts; donor coordination meetings help to facilitate cooperation. This complementarity is also reflected in the technical design of USAID-funded MCH projects.

2.1.1 The Programs

USAID Partners. The three major MCH projects that USAID/Nicaragua supports are PRONICASS, FamiSalud, and HCI. Alliances also has several small health projects. The Title II Development Assistance Program (DAP) child survival projects will end in September 2008. The Child Survival and Health Grants Program (CSHGP) ended September 2007. (See Annex E for an overview of the projects and their interventions.)

PRONICASS. The predecessor to PRONICASS was a 30-month bridge project of the USAID Management and Leadership Project (M&L) begun in 2003 that provided assistance to MINSA in four areas: leadership, health service monitoring, institutional reform, and finances. Those areas were carried over into PRONICASS, which began in September 2005 and is now funded through the Leadership, Management, and Sustainability Project (LMS). In addition to MINSA, PRONICASS works with the Ministry of Education, the Association for Welfare of the Nicaraguan Family (PROFAMILIA), the NicaSalud network, and ENDESA. Within MINSA, more than 40 project staff work on ministry-wide systems, but the practical applications have been in MCH, especially FP, reproductive health, and STI/HIV/AIDS, which traditionally receive about 50 percent of the total MCH budget. The final health goal of the PRONICASS project is "Better and More Health in the Nicaraguan Population." The project's immediate objective is to help the government to implement MAIS.

FamiSalud is USAID's main vehicle for facilitating community-based MINSA programs to (1) promote and prevent malnutrition in children (Integrated Management of Childhood Illnesses [IMCI] and Community Promotion of Health and Nutrition [PROCOSAN]); (2) support families in drafting a birth plan (*Plan de Parto*); (3) promote and provide FP services to hard-to-reach populations (ECMAC); and (4) disinfect drinking water. FamiSalud is a three-and-a-half-year project managed by NicaSalud, a network of 28 local and international NGOs. Future budget projections allocate 30 to 39 percent of the total MCH funds for FY08 and 09 to FamiSalud.

FamiSalud aims to (1) strengthen NicaSalud's capacity to work through networks and carry out advocacy to influence policy; (2) reinforce the management capacity of the NicaSalud Federation Network; and (3) develop and implement the Integrated Community Health Program.

Health Care Improvement (HCI). HCI and its predecessor, the Quality Assurance Project (QAP), have been working in Nicaragua since 1999. HCI's area of expertise is quality improvement in essential obstetric and newborn care. It concentrates on improving the quality of service delivery. Initially, it worked in primary care but in the past four years it has been working mostly at the secondary level, in hospitals and health centers with beds. Through Obstetric and Pediatric Improvement Collaboratives, it aims to improve case management of labor, delivery, and postpartum complications and severe illnesses in children under five. Although its main target audience is the public sector, HCI is now working with some private health care facilities that provide services financed by the Nicaraguan Social Security Institute (INSS). USAID/Nicaragua provides field support to this centrally funded project that will total three percent of its total MCH budget obligations for FY08 and 10 percent for FY 09. Other funding for HCI FP and HIV/AIDS activities totals more than the MCH budget.

Alliances forms strategic partnerships with private entities to raise financial and in-kind resources for investments in health and education. Approximately $2 million has been allocated equally to health and education partnerships. This is a three-and-a-half-year centrally funded regional project that receives technical support from the Research Triangle Institute (RTI). Alliances operates with a skeleton staff of two private sector specialists and an administrative assistant. Of 14 projects funded to date, four deal directly with health and one integrates health and education activities.

2.1.2 Achievements

USAID-funded projects have met their indicator targets and achieved more that has not been quantitatively measured. For example, with a nominal budget, USAID partners are working throughout the country in communities and hospitals—an exemplary and highly commendable accomplishment. When this is coupled with institutionalization of the facility-based work and support of MINSA's priorities, it is quite likely that USAID's contribution to the MCH program will be sustainable.

Integrated management of the MCH portfolio is routine at the central level, but integration of USAID-supported services at the community level may not always be seamless—in part by design. There is no indicator to track integration; nor is it built into the implementing partner project objectives. The monthly reproductive health coordination meetings of the major partners work well to avoid duplication of interventions, but it is not clear whether they influence integration at the field level, which appears to be ad hoc. Integrated management of services is ultimately the responsibility of MINSA, but USAID could do more to model it. In some instances, it is the other way around: the same MINSA staff and volunteers are implementing USAID-supported activities en masse. One clear example is the Siuna Health Center in RAAN where a telemedicine project is not being incorporated into other USAID activities in the same health center. USAID-supported community activities do not seem to be directly linked with the work of these other two projects, although that may be because community work here is just starting.

2.1.2.1 PRONICASS

The bridge project that preceded PRONICASS featured four areas: leadership, health monitoring, institutional reform, and finances.

Leadership: Leadership training was given at all levels of MINSA, from the Vice Minister to SILAIS teams and municipal hospital and health center directors. Over 2,000 health staff were trained. As a practical application, leadership participants were given a real issue to resolve: how to harmonize the National Health Plan and the Service Delivery Model.

External qualitative assessments showed improvements in participation, teamwork, and communication skills within the organization. Most important, the harmonization challenge was met.

Health Service Monitoring (AMAS): M&L helped with scaling up, validating, and revising the monitoring guide. It also created a software program to facilitate use of the guide and validated the utility of AMAS. There were demonstrated improvements in planning, organization, monitoring, and decision-making. An important conclusion was that if a health unit improves on the processes measured by AMAS, it will improve MCH service coverage.

Institutional Reform: Substantive long-term support so far has been limited to development of a health care model and institutional reorganization. Concurrently, Management Sciences for Health (MSH) was providing restructuring assistance to MINSA. Major products developed were the health care model, operational manuals, norms for integrated care of women of reproductive age, and guidelines for the design of health care protocols.

Finances: M&L helped MINSA organize its National Health Accounts and an integrated financial information system.

Current Health Systems Strengthening

- Results-based budgeting and planning
- Norms for service delivery
- Decentralized human resource management
- Institutional capacity building
- Basic package of services
- Management of social services
- Integration of pharmaceutical logistics system
- Nonprofit drug outlets.

NicaSalud: M&L introduced the concept of a business plan to NicaSalud and helped it and five affiliates develop and submit business plans to donors. M&L also helped NicaSalud redesign its financial, human resource, and procurement systems so that USAID could certify it to receive funds. As a result, $8 million of USAID funds for community health were channeled through NicaSalud instead of a U.S.-based organization.

PRONICASS is currently working on strengthening systems in three SILAIS (Nueva Segovia, León, and Boaco) in the following principal areas: institutional reorganization, service models, AMAS, citizen participation, and leadership.

Work is progressing fairly well. For example, this year MINSA introduced results-oriented budgeting; the Ministry of Finance is developing a guide. It is expected that the system will be implemented by 2009. A guide for citizen participation through Municipal Health Councils has been developed but certain political issues must be resolved before it can be implemented. The integrated pharmaceutical logistics system is set to become operational in mid-2008.

The new government is committed to improving conditions at the community level. This is observable in León, a PRONICASS pilot area. Health workers are going house to house to assess

family health status and needs using an instrument (Ficha Familial) that PRONICASS helped design. This is part of a community diagnosis exercise that will eventually cover all sectors in the department and enable each SILAIS to develop comprehensive service plans for meeting community health needs. The intent is to move MINSA from a curative, facility-based system to a prevention and promotional one.

Among the challenges facing MINSA and PRONICASS are reorganizing MINSA, implementing family and community diagnoses, moving medical staff from health centers to the field, getting the HIS up and running, and getting municipal health councils operational.

PRONICASS and HCI are coordinating their work. PRONICASS wants to ensure that the quality improvements that HCI is introducing are incorporated throughout the SILAIS, not just the hospitals. One staffer gave an example: A client satisfaction tool HCI developed years ago is now incorporated in AMAS. But the question is, how well do they monitor its use? Both groups recognize the importance of monitoring whether standards are met.

Systems strengthening is difficult work that requires a great deal of diplomacy from PRONICASS staff. It is clear from interviews with SILAIS staff that the consultants are well-respected and valued. One doctor spoke for the group when she said, “Don’t drop us. We have the designs. Now we need PRONICASS help in implementing those designs.”

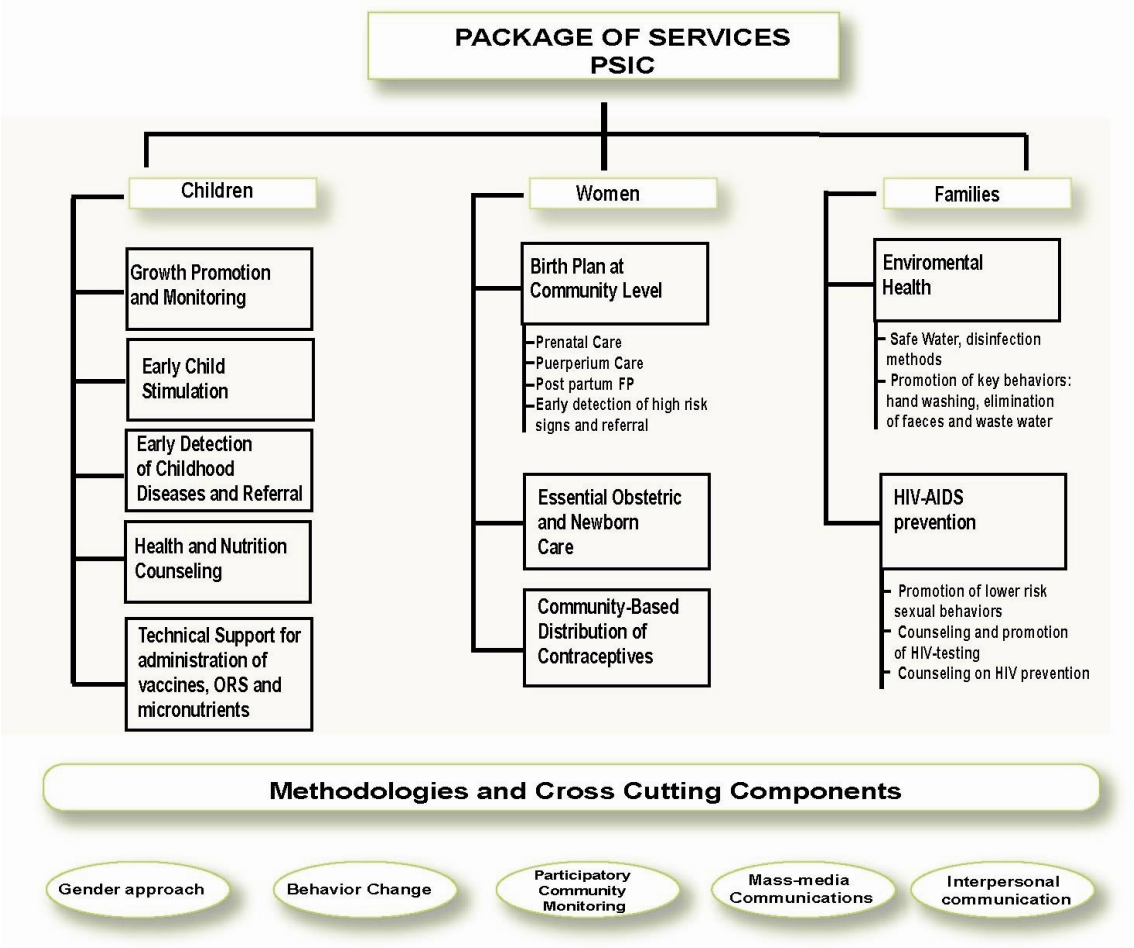
When respondents were asked if they could see any improvement in health behavior or status as a result of the work of PRONICASS on systems improvement, the answer was a guarded “yes, some.” Most, including PRONICASS, agree that it is premature to draw conclusions. It is also difficult to measure changes in mortality and morbidity, much less attribute such changes to MINSA. But it is possible to measure intermediate effects in such areas as client satisfaction, weight gain of infants, and institutional deliveries.

2.1.2.2 FamiSalud

FamiSalud was initiated in April 2006. First, it needed to build its own administrative and financial capabilities, an area where its staff has been experiencing a steep learning curve. However, management capacity is improving with each passing quarter. With help from PRONICASS, FamiSalud became accredited to receive USAID funds in August 2006.

Probably the most critical role for FamiSalud is to help develop and implement its Integrated Community Health Program (known locally as PSIC). This is a program created by NicaSalud. PSIC is a package of MINSA activities that FamiSalud is attempting to expand (see figure 1).

Figure 1: FamiSalud Community Services



Essentially, at this point NGOs are responsible for facilitating most MINSA community programs: PROCOSAN, Plan de Parto, ECMAC, and Agua Segua. FamiSalud is rapidly moving across 12 SILAIS to train, prepare, produce, and disseminate materials and to oversee the programs. It is well-poised to achieve its coverage targets (see Table 4). By design, PROCOSAN is to be implemented in communities first so that local integrated health service systems are in place before the other programs are introduced.

FamiSalud uses the following criteria to select communities: (1) difficulty in reaching a health unit; (2) severe to moderate poverty; and (3) rural setting. Thus 53 percent of the PROCOSAN sites are situated in SILAIS that are above the national average for chronic malnutrition, and 79 percent of the Plan de Parto programs are in SILAIS that are below the national average for facility-based births. Although specific data are not available, the selection criteria should lead the program to the poorest areas where need is greatest.

FamiSalud and MINSA staff work together very well in the field. All training events attract a good proportion of MINSA staff as well as volunteers. In 2007, 1,783 people were trained on PROCOSAN, 1,622 on Plan de Parto, and 1,448 on water disinfection methods. Other training has covered life saving skills, ECMAC, and lot quality assurance

Table 4: FamiSalud Coverage by Program		
Program Strategy	**Goal (Sites)**	**Percent of Goal**
PROCOSAN	1,048	61%
Social sale of medicines	17	47%
Plan de Parto	471	41%
Health Municipal Councils	58	40%
ECMAC	400	38%
Water disinfection method	384	29%

Source: FamiSalud/USAID, 7th Quarterly Report, October-December 2007, NicaSalud Network Federation

Strategy for Monitoring and Evaluation. The complex monitoring and evaluation (M&E) system needed to capture the work of numerous NGOs on a variety of topics is undoubtedly a heavy, though necessary, burden that entails building internal capacity. What is not readily captured in FamiSalud's indicators is the quality of its training. FamiSalud staff and the brigadistas they have trained demonstrate superb facilitating skills. For example, one brigadista patiently awaited a mother's input during a consulting session. Another FamiSalud promoter selected PROCOSAN indicators to generate a discussion that led community members to interpret the results for MINSA staff. FamiSalud staff possess a keen ability to engage community participation and transfer this capacity to brigadistas.

However, FamiSalud's understanding of how to use the network's management systems is limited. For example, it does not seem to have a process for setting priorities for selecting communities and programs. Nor has it been able to describe its strategy for program implementation other than to say that PROCOSAN has been a priority and site selection follows the specified criteria. Thus, although FamiSalud is supposed to be a nationwide effort, it could not adequately describe its scale-up approach to the evaluation team.

In addition to MINSA's pillar community programs, *FamiSalud* supports an array of other activities:

- An avian influenza communication campaign involving a whole host of new stakeholders;
- A Blue Bus to raise community awareness (e.g., of HIV and STIs) and promote healthy behaviors;
- Social pharmacies; and the
- Integrated Nutritional Surveillance System (SIVIN) for MINSA.

2.1.2.3 HCI

There is broad-based consensus that HCI's work has brought dramatic improvements in the management of maternal and newborn care at the secondary level. These successes are being realized at scale in 16 SILAIS where mortality in these two target groups is being reduced. HCI has focused much of its effort on management of the quality of care, including self-monitoring of progress using quality assurance benchmarks. It is lauded by many for its participatory approach. Despite its very limited MCH budget and a team of just six physicians, all respondents

interviewed agreed that HCI has achieved extraordinary results. HCI's director attributes its ability to stretch its development dollars to being able to leverage funds from UN agencies and the Embassy of Luxemburg, and also to having had a clear focus on institutions from the onset. The following are some HIC successes.

Institutionalization of Quality Assurance: One of HCI's most important achievements has been the development of standards of care, guidelines, and protocols for maternal and pediatric care. Previously, it was not unusual to find different norms applied in different hospitals or even within a single hospital. Up to 2003, there was no national guidance on management of critically ill children. HCI enlists multidisciplinary teams to develop these standards and norms. Working with MINSA and SILAIS management and technical experts and advisors from across the country, HCI developed standards for essential obstetric care (EOC), emergency obstetric and newborn care (EmONC), and hospital-based IMCI and adapted them to local settings. It has also developed and adapted associated guidelines, protocols, and job aids, all in collaboration with MINSA, PAHO, UNICEF, and UNFPA.

> One clear example of improved quality procedures was cited by the director of the INSS-supported AMOCSA hospital, who noted increased use of the partograph to monitor patient progress during labor and delivery. The completion rate leaped from 11 percent at the 2004 baseline to 88 percent in 2007.

Another major contribution of HCI has been the use of quality indicators that allow facility staff to better assess their problems. Before HCI started its program, hospitals were measuring only mortality rates, number of cases of a disease (e.g., number of diarrheal and pneumonia cases), and the associated fatality rates. Now, using specific outcome indicators that measure quality of care, providers better understand the effectiveness of their management of patient complications and are guided to practical solutions. Moreover, there is closer collaboration between the private and public sectors. For instance, a private hospital now works much more closely with the government SILAIS than it did before, freely reporting to and reviewing its quality indicators with SILAIS administration.

Coaching at sites is another feature that has been decentralized to the SILAIS level, where HCI has helped MINSA staff to become coaches. However, a significant constraint is that MINSA's transportation budget for coaches to conduct monthly supervision visits is limited.

Quality Improvement in Essential Obstetric and Newborn Care: Training nurses and doctors is central to HCI's strategy for improving the quality of maternal and newborn care. In-service training centers were created to build staff competency in management of acute pediatric illnesses through short rotations and monthly monitoring of quality indicators. Hospital providers now use such internationally established modalities as EOC and EmONC to treat complications during labor, delivery, and the immediate postpartum period. HCI's integrated approach is based on "compliance with clinical protocols, effective counseling of

> Community leaders in Santa Maria, Chinandega, on the border with León mentioned that the Chinandega hospital staff were now much more receptive to patients: "In the past, we were often rejected at the door or treated with disrespect by the staff of Chinandega Hospital. For that reason, we started to use the León Hospital, even though it is farther away for us to travel. But now we are returning once again to our SILAIS hospital in Chinandega because the quality of care has improved a great deal."

mothers and caretakers, continuous quality improvement, and empowered and motivated staff." Some very basic interventions, such as triage for incoming women in labor, have increased both efficiency and patient satisfaction. More complex changes have brought providers to adopt a culture of quality. Most impressive has been their embrace of culturally sensitive service, which has led to more humane care. Many described clear changes in provider behavior, which is unprecedented considering how the brief duration of the program.

Staff in seven HCI-supported facilities visited said that the quality of care has improved significantly due to HCI interventions. Many said that their morbidity and mortality rates had improved, although there were no data to verify this. The Siuna Health Center (a center with beds in RAAN*)*, was thought to have the highest maternal mortality rate in the country. The director believes the number of maternal deaths has decreased radically in the past two years.

EOC and Pediatric Hospital Improvement Collaboratives: HCI began to form improvement collaboratives in 2003. There are 16 Pediatric Hospital Improvement collaboratives (PHI) and 14 EOC collaboratives at the SILAIS level. In November 2006 University Research Corporation (URC) conducted an internal evaluation of these collaboratives, giving special attention to sustainability. In reference to the entire HCI program, the evaluators advised the following:

It would be prudent to ensure that the technical assistance strategy for training and coaching is clear about how the EOC collaborative…will function after QAP technical assistance is phased out….Clarifying the expectations for institutionalizing quality assurance…may help to identify what role key technical MINSA staff may take on.[8]

2.1.2.4 Alliances

Alliances has already met its 2:1 match in funds for health projects, leveraging approximately $2 million from the private sector. In fact, there is pent-up demand from corporations willing to contribute, but USAID matching funds have already been exhausted.

Alliances is funding an innovative project in Siuna RAAN that connects this remote municipality with the main MCH referral hospital. Medical staff in the Siuna Health Center (a center with beds)[9] send ultrasound images of unborn fetuses to experts in Bertha Calderon Hospital in Managua. As providers in both facilities view the image simultaneously, the experts advise Siuna staff on diagnosis and treatment of pregnant women at risk of delivery complications. The Ruben Dario Foundation for Human Development (FUPADE), the NGO partner implementing this project, has begun to expand the reach of its telemedicine capabilities by inviting colleagues in Puerto Cabezas, RAAN, to use the technology. Beyond the health center walls FUPADE takes a comprehensive approach to creating demand for institutional deliveries through radio broadcasts, distribution of IEC materials, and close collaboration with the Casa Materna waiting homes.

Computer labs with Internet connection have been established in all 10 schools of nursing. These "Aulanets" are open to nursing students and staff from nearby hospitals that otherwise would not have access to the current literature and software-based educational tools. HCI's project director joined the site visit to the Aulanet in the Polytechnical University in Managua. Previously unaware of this intervention, he mentioned that HCI could benefit from this resource because it

---

[8] Y.A. Lin and L. DiPrete Brown, "Evaluation Site Visit Report: Nicaragua" October 22—November 4, 2006, Quality Assurance Project, University Research Corporation, Bethesda, Maryland, USA.

[9] All health centers with beds the evaluation team visited were functioning as small hospitals providing secondary care.

has technical software not often used by MINSA counterparts because they have limited access to computers. Five MINSA labs are no longer functioning. The law prohibits these labs from soliciting revolving funds to pay for staff and other operating costs.

Another Alliances-supported intervention is the Rainbow Net Project that integrates several services and health and education promotion activities. USAID funds are thus supporting the continuing work of Arco Iris, a local NGO that provides treatment and prevention services to 18 communities that have no access to government services. Like PROCOSAN, Arco Iris provides growth monitoring and treatment services in addition to supplementary food during an after-school education program.

2.1.2.5 Other Projects

Project HOPE, funded by the CSHGP, has cultivated a public-private partnership that shows promise as a best practice. Coffee plantation owners in Jinotega helped to fund MINSA health services for their employees. Private funds went for medicines, supplies, and support for additional providers in four health posts. They also set up community pharmacies; distribution points for contraceptives; and total quality management training for MINSA and HOPE staff. MINSA has continued its collaboration with the private sector (without Project HOPE's resources) and expanded the model to seven more posts in the region.

2.2 FACILITATING AND LIMITING FACTORS

Respondents were asked to describe factors that contribute to and barriers that impede the success of their interventions. Not all the factors were under their control.

2.2.1 Facilitating Factors

- *Political and personal commitment to implement MINSA programs* was often mentioned. SILAIS management and providers, community health commissions, leaders, and brigadistas are all pivotal to successful interventions.
- Fortunately, there is *very good coordination and collaboration between MINSA, brigadistas, and USAID implementing partners*. Stakeholders appreciate that they share common goals, which eases their individual efforts.
- Because of *government emphasis on quality assurance and support for laws that protect patient rights,* patients now expect and demand quality services.
- *Good communication channels between the health centers and the hospitals* facilitate referrals and counter-referrals.
- There is a *demand from Nicaraguan-based companies to support health and education* with private contributions. *In particular, coffee producers* have demonstrated their commitment to improve health conditions for their workers.

- Brigadistas, who now have *government-issued identification badges,* command more attention and respect from the communities they serve.

2.2.2 Limiting Factors

- There is *frequent turnover of newly graduated physicians,* who have a mandatory social service commitment to work in the public sector. These inexperienced physicians often lack interest in or commitment to their temporary assignments, which sometimes translates into inadequate diagnosis and treatment.
- There has been a history of *patients being rejected at facilities at all levels of care.* MINSA providers are known to reject referrals from brigadistas.
- Conversely, providers complain that *patients often arrive at facilities in an advanced stage of illness,* making their cases more difficult to treat.
- *Termination of Title II/PL480 food rations might worsen nutrition status,* forcing people to make difficult choices between seeking food security or health services.
- *The SILAIS comprising the Northern Region are compromised for a variety of reasons:* underdeveloped infrastructure, difficult geography, religion, and a poorer and less well-educated populace. Some claim that this region has received a disproportionate share of government resources.
- MINSA's strategic emphasis is more on treatment. Mass media are not being used as much as they could be for health promotion.
- There is a tension between traditional birth attendants (parteras) and the formal health system. MINSA has not yet defined roles for the parteras. The fact that they and other community leaders are often illiterate limits their ability to support government programs.
- Underage mothers (less than 16 years) cannot get an identification card and therefore cannot register their children and receive care.
- The coffee-growing season affects leadership and disposable income. Community leaders leave their villages during harvest season. During the off-season, when finances are tight, some say alcohol use and domestic violence increase.

2.3 DISSEMINATION AND SCALING UP

One of the main strengths of the USAID/Nicaragua MCH program is that, by design, the projects are working at scale. HCI is currently working in 16 of the 17 SILAIS and FamiSalud is working in 12. The Alliance Project, the one intentional exception, is the platform for testing new innovations before scaling them up.

The Alliance-supported telemedicine intervention in Siuna, RAAN holds promise. In fact, FUPADE already has taken the initiative to expand to Puerto Cabezas. The FUPADE project director mentioned that she might be invited to describe FUPADE's intervention to a group of SILAIS directors. Most of the costs for this intervention are sunk-capital outlays with few recurrent costs. Also, holders of the software license—currently Siuna Health Center and Bertha Calderon Hospital—can invite any other site with access to join a virtual meeting.[10] Further

[10] One respondent believes that the Swedish International Development Agency is implementing another

investigation is warranted to determine the potential for scaling up this intervention in the Northern Region, where there are few obstetricians and general physicians handle most obstetric emergencies.

The Aulanet computer labs in nursing schools should be examined to resolve operational problems in half the sites. Once they are deemed functional and sustainable, the next step would be to open the service to facility-based providers trained by HCI. These computers are a highly valuable commodity for MINSA staff, who have limited or no access to software-based learning modules and Internet medical research (e.g., the World Health Organization's Cochrane Reproductive Health Library or MEDLINE). Among other far-reaching possibilities is emergency reporting of disease outbreaks.

---

telemedicine project in other SILAIS.

3. HIV/AIDS

3.1 EFFECTIVENESS

This section deals primarily with the interventions of two USAID partners, HCI and PSI/PASMO. Although complementary in that they deal with different aspects of USAID's HIV/AIDS program, they are not formally coordinated.

3.1.1 The Programs

USAID Partners. There are three main interventions that are complementary:

1. *Behavioral change communication* (BCC), which has focused on high-risk groups (female sex workers, men who have sex with men, people living with HIV/AIDS, and others)
2. *Voluntary counseling and testing* (VCT), which combines rapid testing and integrated counseling
3. *Stigma reduction* within health institutions and among the general public.

PSI/PASMO and HCI are the principal partners leading these interventions. PSI/PASMO works largely with high-risk groups and HCI works on integrating quality HIV/AIDS services into MINSA, including PMTCT (prevention of mother-to-child transmission, known locally as vertical transmission). PSI/PASMO has a subcontract with the Institute for Reproductive Health (IRH), which is designing a certification program for VCT.

Other Partners. Four other USAID-funded organizations are involved peripherally in HIV/AIDS activities in Nicaragua:

- **The Capacity Project** is undertaking a study of HIV/AIDS performance in three hospitals and is creating a human rights course that was to have been tested in Nicaragua in March. It also drawing up plans for a pilot income-generating project for artisans with HIV.
- **Abt Associates** does generic social marketing.[11] It has also undertaken a mapping exercise and some research in Nicaragua.
- The **Centers for Disease Control** (CDC) has regional funding to provide technical assistance to MINSA but does not have any specific activities as yet. Several options have been suggested, including development of a sentinel surveillance system, a survey of seroprevalence, and behavioral surveillance studies of high-risk groups.
- **FamiSalud** has a bilateral grant to provide MCH services, including HIV/AIDS, at the local level, but the project is barely underway as yet.

Objectives. Both HCI and PASMO have the same general objective: prevent the spread of HIV/AIDS in Nicaragua, especially among high-risk groups. However, they target different populations.

---

[11] It takes a "total market" approach, meaning that it promotes all condoms, not any particular brand.

The HCI Program. Until 2006 only three hospitals in Nicaragua offered antiretroviral therapy (ART) and rapid HIV tests, and only one organization, the National Reference Laboratory in Managua, offered confirmatory tests. Results took a month or more to produce. Prenatal HIV testing was not promoted, and although FP counseling was provided routinely to pregnant women, FP and STI/HIV/AIDS were separate vertical programs.

MINSA asked HCI to help develop a model of care that would incorporate strategies for prevention of vertical transmission from mother to child at both the primary and secondary levels of care. The goal was to increase VCT among pregnant women to identify those who were HIV-positive and to reinforce HIV–prevention behaviors among pregnant women. Concurrently, HCI was to work with hospital staff to reduce stigma and discrimination. Although pregnant women are a low-risk population, USAID saw this as an opportunity to get a foot in the door with MINSA and eventually help MINSA set up procedures to identify, serve, and follow up with high-risk groups.

The PSI/PASMO Program. In December 2005 USAID entered into a cooperative agreement with PSI to contain the spread of HIV/AIDS in Central America and Mexico. The PSI/PASMO program aims to motivate high-prevalence and vulnerable populations to say "no" to sex, reduce the number of sexual partners, use condoms consistently, find out their HIV status, and treat sexually transmitted infections (STI) correctly. The approach is based on a strategic blend of interventions to change individual behavior and coordination and improvement at the service delivery level.

Voluntary Testing and Counseling (VCT) is one of the most effective HIV interventions; MINSA, HCI, and PASMO all support its expansion. MINSA and HCI supplement their testing with integrated counseling. This means that MINSA can call on the multidisciplinary HIV team to provide psychological, medical, economic, and whatever other counseling the HIV-positive patient might need. This is in line with MINSA's commitment to quality and integrated care for all patients.

In Nicaragua PSI/PASMO works with female sex workers, men who have sex with men, persons living with HIV/AIDS, transvestites, and groups that are actual or potential clients of sex workers, such as truckers, the military, migrants, indigenous populations, and prisoners. This year PSI/PASMO is opening five new service sites along the frontier with Honduras and on the Caribbean coast, which will give it more contact with high-prevalence migrants and indigenous groups.

To ensure consistent service delivery, PSI/PASMO has a subagreement with the IRH to strengthen the quality of VCT/STI services in both public and NGO sites. IRH has prepared standards for VCT and created a certification program that is being tested in five SILAIS.

3.1.2 Achievements

3.1.2.1 HCI

By 2007 HCI had broadened its goal somewhat. Its current work plan calls for HCI to "support the organization of high quality services for HIV prevention, counseling and testing, and treatment among high-risk populations in 14 SILAIS, including activities to reduce stigma and discrimination and to improve logistical management of HIV tests and antiretroviral drugs."[12]

Workshops for medical staff on **stigma and discrimination** have had a positive effect. One physician in Chinandega who took the course along with 24 colleagues said that most knew nothing about HIV/AIDS before they took the course. The result is better, faster, and cheaper treatment of HIV/AIDS cases. Not only does he want more groups trained, he is willing to do the training himself.

In general the HCI project has been very effective in meeting, and surpassing, its objectives. It has done very well in developing quality standards and indicators to measure adherence to them; introducing rapid testing in health centers and confirmatory testing in departmental hospitals; organizing workshops for health personnel and people living with HIV/AIDS to reduce stigma and discrimination; forming multidisciplinary HIV/AIDS support teams; and developing mechanisms to promote sharing of successful strategies across teams. The multidisciplinary team at Matagalpa Hospital is setting up a separate unit to care for AIDS patients. By the end of February 2008 HIV/AIDS services had expanded to 16 (76 percent) of the 21 hospitals with MCH services and 87 (49 percent) of the 177 health centers in the country.

Table 5: HIVAIDS Indicators 2008[13]

Indicators	Numerator	Denominator	Percent
Pregnant women in ANC who were counseled about HIV/AIDS	1,187	1,330	89.2
Pregnant women who were counseled about HIV/AIDS and were tested for HIV	942	1,330	70.8
Pregnant women who were tested for HIV and received the results in the time established	894	942	94.9
Women of reproductive age who attended FP services and were counseled on FP and HIV/AIDS	861	1,154	74.6
Women of reproductive age (not pregnant) who attended FP services, were counseled on HIV, and were tested	459	1,154	39.8

Initially, the percentage of women counseled who were also tested was relatively low. In 2007 the percentage of women in prenatal care who were counseled on HIV/AIDS was very good, 72 percent, but only 36 percent of those women agreed to an HIV test. Similarly, the percentage of women of reproductive age who were not pregnant and received FP and HIV/AIDS counseling

[12] HCI Project First Year Work Plan.doc.

[13] HCI, February 2007.

was 71 percent, but only 26 percent of those agreed to a test.[14] However, HCI data for 2008 show that the percentage of pregnant women who were both counseled and tested has increased to 71 percent, though the percentage of women of reproductive age (not pregnant) who were both counseled and tested was only 40 percent, which is still better than the 2007 data. There are no data on the number of women who tested positive.

Hospital staff in some of the sites visited stated that the 2007 figures were "pre-rapid testing." Now that test results can be produced the same day, the VCT acceptance rate has climbed to about 70 percent.[15]

Recently HCI has broadened its target groups to include high-risk patients, in particular, men and women who come to health centers with an STI. HCI has also broadened its VCT training. So far 471 health providers (doctors and nurses) and 165 laboratory technicians from 73 health centers and 13 hospitals have been trained in quality VCT. MINSA is impressed by HCI's success and has expressed interest in expanding it nationwide.

Follow-up is a serious problem. One doctor who treats HIV/AIDS patients noted that some do show up for their monthly appointments. They may be sick, cannot afford the transportation, or forget. The hospital has no outreach, no computerized record-keeping system, and no way of contacting these patients. "We need to set up a system so we don't lose these people," he said.

As positive as these results are, there is one area that is somewhat problematic. That is the emphasis, or lack thereof, on prevention and treatment among high-risk and vulnerable populations (especially female sex workers, men who have sex with men, and people living with HIV/AIDS). Pregnant women, initially the program's main target group, are low-risk. The program is facility-based and has no mechanism for identifying or serving people outside hospitals and health centers, where the high-risk populations are found. The recent shift in target groups to include patients with STIs is welcome, but much more needs to be done.

There have been complaints from some patients about discrimination, poor counseling, poor testing technique, and long waiting lines at health centers. These problems may reflect sites where VCT training has not yet been undertaken, for example, in Managua, where HCI does not work.

3.1.2.1 PSI/PASMO

PSI/PASMO achievements are also impressive. It has used bilateral funds from USAID/Nicaragua to scale up program coverage, add new target groups, add sites where high-risk groups can be found, produce and distribute additional materials, and hire more outreach staff. Key outputs for FY 2007 are shown in Table 6. Through September 2007, 1,838 BCC activities had been carried out funding for at-risk populations along the Atlantic Coast and in the areas bordering Honduras and Costa Rica. The total number of individuals contacted was 32,414 (21,757 males and 10,657 females).

The table also shows activities and contacts made with regional support (G-CAP) and the combined totals. PSI/PASMO has exceeded all targets except for the one dealing with people living with HIV/AIDS—why is not clear.

---

[14] QAP Nicaragua Annual Report and Directions (7/06-6/07), p. 13

[15] Dra. Nelly Martinica, NicaSalud, personal communication, 2/29/2008.

While USAID funds are not targeted to youth, PSI/PASMO receives funds from other donors to set up youth clubs, and activities for men who have sex with men and female sex workers often reach youth.

Table 6: Summary of Nicaragua Bilateral Outputs: FY 2007

Target Groups	Nicaragua										
	G-CAP			Bilateral			Total			% of Targets Reached	
	ACT	CONTACTS		ACT	CONTACTS		ACT	CONTACTS		ACT	CON
		M	F		M	F		M	F		
Men who have sex with men	2,133	33,086	0	319	4,569	0	2,452	37,655	0	105%	133%
Female sex workers	2,002	0	29,843	531	0	6,847	2,533	0	36,690	144%	178%
Potential clients	1,349	47,382	0	564	11,704	0	1,913	59,086	0	122%	129%
People living with HIV/AIDS	21	127	102	97	661	395	118	788	497	63%	57%
Caribbean population	0	0	0	308	2,721	1,685	308	2,721	1,685	NA	NA
Others	129	19,253	18,526	19	2,102	1,730	148	21,355	20,256	0%	0%
Total	**5,634**	**99,848**	**48,471**	**1,838**	**21,757**	**10,657**	**7,472**	**121,605**	**59,128**	**118%**	**116%**

ACT = Activity—a programmed event; CON = Contact—an individual reached.

Yader is an exceptional promoter. He covers the whole of the Occident on his motorbike, averaging six activities a day at different sites for different groups. He carries his promotional tools with him in a small bag. He uses five different interactive programs. He says he has never been rejected. He'll go wherever he can find high-risk groups congregating: bus stops, ports, parks, gas stations. He has a novel way of getting to men who have sex with men: They meet at a group leader's home, often on the weekends. There he makes his pitch and answers questions. They are very respectful, he says.

The IRH subcontract had a slow start. The diagnostic survey of compliance with VCT standards, especially counseling skills and procedures, took time to process, and more time was taken to develop and test the VCT model. The certification process takes four months. Thus, by the end of the third year only nine providers in Bluefields had been certified and 11 others in various NGOs from 4 SILAIS were completing their certification. When the project ends later this year IRH hopes to turn the methodology over to MINSA to implement. The plan is to start in León with decentralization to all levels and integration of HIV/AIDS messages in all services.

Because Nicaragua also receives support from the regional G-CAP office, it can be difficult to determine what was paid for with USAID bilateral funds and what with G-CAP funds. Even more confusing is that G-CAP provides funds to Abt Associates to carry out certain activities and PSI to carry out others. Moreover, PASMO is an independent, completely self-sustainable social marketing business that sells condoms and uses the proceeds to support other activities. It promotes condom sales in the same high-risk areas

where PSI/PASMO works. Although they are clearly complementary, it is difficult to sort out what each single mechanism is doing and achieving (see Table 7).

Table 7: PASMO Funding						
Donors	**Dutch Embassy**	**USAID G-CAP**	**USAID Bilateral**	**USAID Abt**	**UNICEF**	**PASMO Funds**
Duration	Sept 2005-Feb 2009	Dec 2005-Sep 2009	Dec 2005-Sep 2009	Dec 2005-Sep 2009	Jul-Dec 2006	Ongoing
Activities	Social marketing of branded condoms for FP and HIV/AIDS			Social marketing of generic condoms; total marketing approach		Social marketing of branded condoms for FP and HIV/AIDS
	Social marketing of orals and injectables					
	Youth Club				Youth Club	Youth Club
	BCC for high-risk groups	BCC for high-risk groups	BCC for high-risk groups			
		VCT Quality Certification **(IRH Sub)**				

PSI/PASMO provides some output data in its reports. Table 8 shows an excerpt for Nicaragua on the type of BCC intervention used. This is probably a good indicator of what works and what does not.

Table 8: Interpersonal Activities by Intervention, Nicaragua, FY 2007						
Nicaragua						
	G-CAP		**Bilateral**		**Total**	
IPC Programs	**ACT**	**CON**	**ACT**	**CON**	**ACT**	**CON**
Street information	548	68,839	49	7,195	597	76,034
Outreach	2,586	39,647	724	9,835	3,310	49,482
123 Saludable	1,000	10,946	358	3,811	1,358	14,757
El Reto	992	10,827	376	3,900	1,368	14,727
Espacio P	209	11,150	55	2,778	264	13,928
Kioscos	21	3,526	9	1,446	30	4,972
Charlas	74	1,060	257	3,349	331	4,409
Live the life	199	2,231	8	74	207	2,305
Others	5	93	2	26	7	119
Participatory tour	0	0	0	0	0	0
Total	**5,634**	**148,319**	**1,838**	**32,414**	**7,472**	**180,733**

There should be no doubt that PSI/PASMO is meeting, and usually exceeding, its output objectives. With the possible exception of IRH, which has only managed to certify 20 people over a three-year period, PSI/PASMO's achievements are impressive indeed. Nevertheless, the question must be raised: Has there been actual behavior change? Are these high-risk individuals adopting safe-sex behavior, are they getting tested, and are infections going down? Answering these questions will require behavioral and prevalence surveys.

3.2 FACILITATING AND LIMITING FACTORS

Some factors that are beyond the control of USAID and its partners have affected performance—sometimes positively, sometimes negatively. The following were some of the most important.

3.2.1 Facilitating Factors

- HCI's nine-year history in Nicaragua and its excellent reputation have contributed significantly to its success in HIV/AIDS activities. The same can be said of PSI. Both organizations have been lauded by Nicaraguan managers and staff as professional, responsive, respectful, and highly qualified.
- Some donors have been providing supplies, such as test kits, which helps advance progress.
- Police, military officers, and other authority figures have been very supportive of HIV/AIDS interventions in some areas, though they restrict activities in others (e.g., RAAN and RAAS).
- MINSA and NGOs are very open to consultants and their suggestions.
- The broad use of Global Fund grant funds and involvement of 15 or more public and private organizations in the Country Coordinating Mechanism complements USAID and MINSA objectives.

One promotora noted that she has been in this line of work for 13 years and has never had a problem. The people she talks to are very respectful, she says, whether in a bar or military base or on the street. "You just have to provide a quality product," she says. MINSA does not provide any help at all in her area. She does not know why but she thinks it may be because they would have to work at night and they do not want to, or are afraid to.

3.2.2 Limiting Factors

- The change in government has affected both organizations, causing delays due to replacement of ministers, managers, and key staff. However, most respondents, including USAID officers in other sectors, found little change in operations at either the central and local levels of government.
- A six-month doctor's strike (November 2005–May 2006) also caused delays.
- Understaffed government offices cause further delays.
- Some staff have been pulled off their jobs to deal with health and other crises.
- MINSA has often changed its plans and schedules, causing further delays.
- The lack of accurate survey data on behavior and prevalence hampers planning and evaluation.

- Three different planning calendars (USAID: July-June; MINSA: January-December; U.S. Government: October-September) eat up time and cause duplication.
- Lack of political commitment to reform slows progress.
- Lack of HIV/AIDS promotion by MINSA, especially about which groups are high-risk, curtails progress on key programs.
- The application of Global Fund monies to government agencies, slow implementation, and the lack of significant funding for high-risk groups are also problems.
- FP clients who want long-term methods are sometimes frustrated by MINSA pushing condoms to prevent HIV infections. By law USAID funds cannot be used to promote one contraceptive over another, and MINSA has been advised to address this issue.
- Poverty, low education, and cultural issues in rural communities in particular affect the pace and scope of programming.

3.3 DISSEMINATION AND SCALING UP

Over the years HCI has developed a number of tools and procedures that could be useful in other programs and countries (see box). Among these are multi-disciplinary HIV/AIDS teams, clinical rotations to strengthen the teams, guidelines and treatment protocols, a rapid testing algorithm, and a bar-coding system for HIV test samples.

Replicable BCC/ IPC Approaches
El Reto
123 Saludable
Outreach
Live the life
Espacio P
Kioscos
Charlas
Street Information
Participatory Tours

HCI has also helped identify and train interdisciplinary groups of medical staff on countering stigma and discrimination. Anyone who has gone through the training could easily replicate it at very little cost if given a brief training-of-trainers course. The HCI training program for VCT should also be scaled up to cover the entire country. HCI is not working in Managua or Masaya, where infections are the highest. A collaborative effort with PASMO on VCT training would be very welcome.

PSI/PASMO has developed and disseminated a number of effective interpersonal communication approaches. Most could be adapted to other health promotion activities, including reproductive health and child survival. PSI/PASMO is also developing a "social franchising" model for VCT that would give private and public providers the training, equipment, and supplies they need to educate, counsel, and test clients for HIV at convenient locations at reasonable cost.

Some PSI/PASMO outreach workers have devised innovative techniques that could easily be expanded into other parts of the country. One has been very effective in reaching one of the most difficult and highest-risk populations. The outreach worker contacts a known man who has sex with men who agrees to call a meeting at his house, shop, or other meeting place to learn about preventing HIV infections. By word of mouth, members of the group introduce the promoter to other group leaders.

ANNEX 1: STATEMENT OF WORK

USAID/Nicaragua Health Program
External Assessment Team
(Revised GH Tech: 1-15-08, USAID: 1.14.08)

I. PURPOSE

This request sets forth guidelines for an external assessment of USAID/Nicaragua's health program, which includes activities funded under the Child Survival and Health Account

Specifically, the results of this evaluation will be used to provide the basis for USAID/Nicaragua to determine future maternal and child health program priorities. The recent Family Planning Graduation Plan for USAID/Nicaragua (currently in draft) provides the assessment and recommended priorities for family planning/reproductive health, so this evaluation will not encompass family planning, except by reference.

The objectives of this evaluation are to:

1. Determine the effectiveness of the current maternal and child health approach used and outcomes achieved.
2. Identify key approaches and materials that should be finalized and/or disseminated for the benefit of USAID/Nicaragua supported efforts.
3. Identify strategic priorities for USAID/Nicaragua's future MCH program.

It is expected that this evaluation will begin in early February and will be completed by the end of April 2008.

II. BACKGROUND

USAID returned to Nicaragua in 1991 and has implemented a robust health program since that time, totaling approximately $139 million (not including USAID/Washington investments in Nicaragua) and addressing maternal and child health, water and sanitation, family planning and reproductive health, and HIV/AIDS. Roughly one-third of these funds were designated for family planning and reproductive health programs. Following Hurricane Mitch in 1998, USAID expanded its program to include a substantial component for infrastructure improvements.

USAID assistance has been provided under a series of Strategic Objective Agreements (SOAG), the first covering the period of 1993–1998, the second from 1999–2003, and the third, current agreement, from 2003–2008. USAID has consistently been one of the leading donors in health assistance in Nicaragua, working closely with the government of Nicaragua, the private sector, and multiple local NGOs. Under the current strategy, USAID/Nicaragua is working to impact maternal and child health through improved public and private health management and better family health practices.

The first component necessary to achieve this strategy has been identified as "increased and improved social sector investments and transparency." This has been addressed through technical assistance and training provided to central and local levels of the Ministry of Health (*MINSA*),

Ministry of the Family (MiFamilia), and National Social Security Institute (INSS) to support decentralization and restructuring of government systems to improve equitable and transparent planning and results based budgeting, as well as strengthening of the financial management, procurement, and logistic systems in the social ministries. USAID/Nicaragua has also promoted private sector alliances to increase investment opportunities in the health sector through technical assistance, provision of matching funds, and coordination.

The second component identified as crucial to achieving our goal is "improved integrated management of child and reproductive health." This component builds upon specific successes gained in programs for child survival and nutrition, maternal health, family planning, and reproductive health, taking these to a much larger scale and creating the conditions for nationwide impact. USAID support and assistance for this integrated package of activities has been accomplished through nationwide implementation of *MINSA*'s *PROCOSAN* program (Community Health and Nutrition Program—also known in USAID programs as AIN) which includes immunizations, diarrhea and pneumonia management, increased exclusive breast feeding, hand washing, hygiene, water treatment, and growth monitoring for children up to 2 years of age. Actions undertaken in this area include the nationwide scale-up of: (1) community-based growth promotion, particularly for children in at-risk or vulnerable communities; (2) social communication for household and community behavior change; and (3) enhanced quality of care and expanded access for maternal child health (MCH) services and reproductive health care, including sustainable access to contraceptives and voluntary family planning.

USAID/Nicaragua's current Strategic Objective Agreement (SOAG) funding ends in September 2008 with implementation continuing through September 2009. Major implementing partners working under this SOAG include Research Triangle International with the Alliances for Health and Education project; the NicaSalud Federation implementing the *FamiSalud* project; Management Sciences for Health with the *PRONICASS* project; University Research Corporation with the Quality Assurance Project; Population Services International with the PASMO Behavior Change Communications project; Abt Associates with the PASMO Condom Availability project; and BANPRO and Finarca with the Development Credit Authority guarantees. USAID/Nicaragua's Trade and Agriculture Office (TAO) will be undertaking an evaluation of the entire Food for Peace program implemented in Nicaragua by the Adventist Development and Relief Agency (ADRA), Catholic Relief Services (CRS), Project Concern International (PCI), and Save the Children Federation (SCF), which is ending in 2008. This evaluation acknowledges the important work of the PL 480 Program but concentrates on CSH-funded health activities for which funding is expected to continue.

III. EVALUATION OBJECTIVES

The evaluation team will assess the progress made to date in achieving the specific objectives stated in USAID/Nicaragua's SOAG and review the programmatic and technical strengths and weaknesses of USAID/Nicaragua's CSH-funded health program by addressing the following evaluation objectives. Based on the findings, the team will present results achieved to date, document lessons learned, and present recommendations for future activities.

Objective 1: Determine the effectiveness of the current health approach used and outcomes achieved.

1. Assess the suitability/success of the MCH program, including HIV/AIDS activities.
    a. Does the program sufficiently address areas of need, as specified in the SOAG (relevance)?
    b. Does the program support the Ministry of Health priorities (relevance)?
    c. Is the program achieving satisfactory progress toward its stated objectives? (effectiveness)? What is the likelihood of meeting the objectives by the end of the program period?
    d. Is the program sufficiently flexible to meet changing needs and unplanned events?
    e. Are USAID's programs complementary to those being implemented by other USG agencies and other donors?
2. Assess the rationale, quality, and outcomes/results of maternal and child health activities planned and implemented to date (i.e., approach(es) developed; information shared among USAID partners, between countries, etc.).
    a. What has worked well within the health program?
    b. What problems and/or obstacles exist that require further tuning?
    c. How can we prove that results are attributable to USAID efforts?
3. Assess the rationale, quality, and outcomes/results of activities not originally planned that technical assistance partners have carried out in connection with or as a consequence of planned activities and work/presence in the field.
4. Discuss the sustainability of the health program activities/impact (may need to be modified/refined due to absence of health systems expert. Team will discuss possible revisions with Mission when in country to determine what can reasonably be completed by GH Tech team members).
    a. Are advances achieved through USAID's health program assistance in the public sector institutionalized and sustainable?
    b. Are new community NGO activities and private sector partnerships sustainable? If not, suggest how they might be.

Objective 2: identify key approaches and materials that should be finalized and/or disseminated for the benefit of USAID/Nicaragua-supported efforts.

1. Discuss the applicability of the approaches and materials developed under this program.
    a. Are these approaches and materials disseminated all USAID-funded projects? If not, how might this be improved?
    b. How might the approaches and materials be disseminated among other stakeholders, including the MOH and other donors?

2. How could USAID/Nicaragua systematize the process of material dissemination among local partners, including the MOH, other donors, and USAID-funded implementing partners?

Objective 3: Identify strategic priorities for USAID/Nicaragua's future health program.

1. Discuss the priorities that should be addressed in USAID/Nicaragua's next health strategy, which will be funded primarily with CSH funds, as currently understood.

    a. Given the results of the ENDESA 2006/7, the results of the USAID efforts to date, other donor assistance, and other appropriate analysis, what are the recommended priority areas for USAID future health assistance (in order of ranking or weighting assuming the same and lower funding levels)?

    b. Given the extent, severity, and trend of the HIV/AIDS epidemic in Nicaragua and USAID guidelines, what is the recommended set of activities if the funding in this area substantially increases?

    c. What would be the recommended implementing mechanisms for reducing management intensity by Mission yet ensuring sound program implementation?

    d. Should any of the current projects be extended? Please explain.

    e. How can USAID/Nicaragua best capitalize on the work that has been accomplished to date and leverage that for future health improvement?

1. Identify possible areas of collaboration in future programming with other USAID/Nicaragua technical offices.

IV. METHODOLOGY

The evaluation team is expected to propose a detailed methodology for collecting the necessary information and data. This should include a description of how the methodology responds to the above tasks and questions; and from whom, and how the data will be collected and analyzed. The methodology should be collaborative and participatory, including plans for conducting interviews with implementing partners and key stakeholders at both the local and national level. The plan should also include a full review of background materials provided, such as annual reports and important protocols developed.

The methodology will be discussed and developed during the Team Planning Meeting (TPM).

V. DELIVERABLES

Work Plan: During the Team Planning Meeting**, t**he team will prepare a detailed work plan, which shall include the methodologies to be used in this assessment. The work plan shall be sent to USAID/Nicaragua for approval no later than the sixth day of work on this evaluation (see detailed time table, below).

USAID Debrief: The team will present the major findings to a USAID/Nicaragua audience through a PowerPoint presentation before the conclusion of the in-country evaluation work. This debrief will include a discussion of past achievements and issues, as well as any recommendations the team has for future programming.

Stakeholder/Partner Debrief: The team will present the major findings to USAID partners and stakeholders (as appropriate) through a PowerPoint presentation before the conclusion of the in-country evaluation work and following the USAID debrief. This presentation will include only findings on past accomplishments and activities, with no recommendations for future programming.

Preliminary Report: The team will submit a preliminary report including findings and recommendations upon completion of the field work and before the team departs Nicaragua. This report should not exceed 15 pages in length (not including appendices, lists of contacts, etc.). This draft will include findings and recommendations for Mission review. USAID/Nicaragua will have two weeks to provide comments and suggestions to the evaluation team, which shall be addressed in the final report.

Final Report: The team will submit a final report no later than one week after USAID/Nicaragua provides written comments on the team preliminary draft report (noted above). This report should not exceed 25 pages in length (not including appendices, lists of contacts, etc.). The format will include executive summary, table of contents, findings, and recommendations. The report will be submitted in English, electronically. The report will be disseminated within USAID. A second version of this report excluding any potentially procurement-sensitive information will be submitted (also electronically, in English) for dissemination among implementing partners and stakeholders.

The final report document will be edited/formatted by GH Tech and provided to USAID/Nicaragua approximately one month after the Mission has reviewed the content and approved the final revised version of the report. This final revised version of the report can be used as a working document while final report editing/formatting is in process by GH Tech.

VI. REFERENCE MATERIALS

USAID/Nicaragua will give guidance and provide the evaluators with the reference materials (hard copy and/or electronic links) required for the development of the evaluation instruments. Annex 1 provides a detailed list of reports, studies, protocols, and other documents that the team should review and take into consideration when preparing for and conducting the evaluation. The evaluation team is expected to collect and annotate additional documents and materials as available.

VII. TEAM COMPOSITION AND QUALIFICATIONS

The evaluation team shall consist of a Team Leader/Maternal and Child Health Specialist, an HIV/AIDS Specialist, and a Health Systems Specialist.

Team Leader/ HIV/AIDS Specialist with at least 10 years of experience with USG-funded HIV/AIDS program design, implementation and analysis. He/she should have experience in program assessment and evaluation methodologies. He/she should have a postgraduate degree in public health or medicine, with extensive experience in public health aspects of HIV/AIDS prevention, care, and treatment. Excellent oral and written Spanish skills are required. The Team Leader should also have experience leading evaluation teams and preparing high-quality project documents. He/she should have a postgraduate degree in public health or an applicable social sciences field. Excellent oral and written Spanish skills are required.

The Team Leader will provide leadership for the team, finalize the evaluation methodology design, coordinate activities, arrange periodic team meetings, consolidate individual input from

team members, and coordinate the process of assembling the final findings and recommendations into a high-quality document. He/she will be responsible for writing the final report and leading the preparation and presentation of key findings and recommendations to USAID/Nicaragua, implementing partners, stakeholders, and others, as appropriate.

Maternal and Child Health Specialist with at least 10 years experience designing, implementing, and evaluating USAID-funded maternal and child health programs, especially in the LAC region. He/she should have extensive experience conducting qualitative research as well as using monitoring and evaluation data. Familiarity with HIV/AIDS and Health Systems programming issues is desirable.

The MCH Specialist will participate in the design of the evaluation methodology and all team meetings, conduct interviews with USAID/Nicaragua and its implementing partners and stakeholders, and provide key findings and recommendations to the Team Leader for the final report. He/she will participate in the presentation of key findings and recommendation to USAID/Nicaragua, implementing partners, stakeholders, and others, as appropriate.

Team Planning Meeting Facilitator (Note: This TPM may be held in the US depending on Mission preference and availability of in-country facilitator.) The facilitator will organize and plan, in collaboration with the GH Tech Project and USAID/Nicaragua, the Team Planning Meeting. He/she will facilitate the TPM meeting and foster consensus on the following items:

- Work plan (including work plan for field visits)
- Timeline
- Roles and responsibilities of team members, USAID clients, and stakeholders
- Methods/approaches to be used in implementing the assessment
- Communications between team members and with USAID and GH Tech
- Outline for report
- Other topics, as appropriate

VIII. LOGISTICS

USAID/Nicaragua will provide overall direction to the evaluation team, identify key documents, and assist in facilitating a work plan. USAID/Nicaragua will assist in arranging and/or participate in meetings with key stakeholders as identified by USAID prior to the initiation of field work. The evaluation team is responsible for arranging other meetings as identified during the course of this evaluation and advising USAID/Nicaragua prior to each of those meetings. The evaluation team is also responsible for arranging vehicle rental and drivers as needed for site visits around and outside of Managua (all site visits will be within driving distance of Managua, no flights will be required). USAID/Nicaragua personnel shall be available to the team for consultations regarding sources and technical issues, before and during the evaluation process.

USAID/Nicaragua will arrange, at a minimum, the following meetings:

1. **Arrival Meeting** upon the evaluation team's arrival in Managua. This meeting will allow the team and USAID/Nicaragua to review the scope of work and evaluation methodology, finalize the key research questions, and examine the evaluation schedule.
2. **Mid-evaluation Meeting** midway through the team's field work. The team and USAID/Nicaragua will discuss the findings to date and troubleshoot possible obstacles toward completing the evaluation as planned.
3. **USAID Debrief Meeting** to be held at the conclusion of the field work for USAID/Nicaragua staff. In this meeting the evaluation team will present the major findings and recommendations through a PowerPoint presentation. The preliminary report will be presented and discussed at this meeting. This meeting will be conducted in English.
4. **Stakeholder/Partner Debrief Meeting** to be held at the conclusion of the field work and following the USAID debrief. The audience will include USAID partners and stakeholders (as appropriate). In this meeting the evaluation team will present findings on past accomplishments and activities, with no recommendations for future programming. This meeting will be conducted in Spanish.

IX. PERIOD OF PERFORMANCE

USAID anticipates that the evaluation will begin in early February and will be completed in March 2008, including preparation days, field work, report writing, and report finalization. A 6-day work week is authorized while in Nicaragua. Anticipated activities include:

Activity	Who	Estimated LOE
Pre-field work activities		
Background reading	Team Leader/HIV Specialist MCH Specialist	3 3
Team planning meeting	Team Leader/HIV Specialist MCH Specialist Team Planning Meeting Facilitator (one day prep)	2 2 3
Field work		
Travel to Nicaragua	Team Leader/HIV Specialist MCH Specialist	1 1
Arrival Meeting	USAID/Nicaragua Team Leader/HIV Specialist MCH Specialist	 1 1
Implementing Partner Interviews	Alliances (RTI) *FamiSalud* (NicaSalud) *PRONICASS* (MSH) Quality Assurance Project (URC) DELIVER Project Development Assistance Projects (ADRA, CRS, PCI, SCF) Child Survival and Health Grants (CARE, Project HOPE)	

Activity	Who	Estimated LOE
	Development Credit Authority (BANPRO, Finarca) Pan-American Social Marketing Organization (PASMO/PSI) PROFAMILIA ProMujer Team Leader/HIV Specialist MCH Specialist	 10 (including Saturdays) 10 (including Saturdays)
Mid-evaluation Meeting	USAID/Nicaragua Team Leader/HIV Specialist MCH Specialist	 1 1
Stakeholder Interviews	Ministry of Health (*MINSA*) Ministry of the Family (MiFamilia) National Social Services Institute (INSS) National Institute of Development Information (INIDE) Pan American Health Organization UNICEF/UNAIDS/UNFPA World Bank Inter-American Development Bank Team Leader/HIV Specialist MCH Specialist	 5 5
Beneficiary Interviews	Local Health System (*SILAIS*) Officials (2–3 departments) Community Leaders (2–3 departments) Service Users/Beneficiaries (2–3 departments) Team Leader/HIV Specialist MCH Specialist	 5 (including Saturdays) 5 (including Saturdays)
Report Writing	Team Leader/HIV Specialist MCH Specialist	5 5
Debrief Meeting	USAID/Nicaragua Team Leader/HIV Specialist MCH Specialist	 1 1 1
Return travel	Team Leader/HIV Specialist MCH Specialist	1 1
Post-field work activities		
Report Finalization	Team Leader/HIV Specialist MCH Specialist	5 5
TOTAL LOES	Team Planning Facilitator Team Leader/HIV Specialist MCH Specialist	3 days Est. 40 days Est. 40 days Est.

X. FUNDING

This activity will be funded through an MAARD issued by USAID/Nicaragua.

XI. CONTACT INFORMATION

Heather Smith, Health Development Officer in USAID/Nicaragua, will be the point of contact for this assignment.

ANNEX 2: DOCUMENTS REVIEWED

1. ABT ASSOCIATES

1. Validación Campana de Categoria para Canal de Alto Riesgo
2. Annual Performance Monitoring Report, October 2006–March 2007
3. USAID Program for HIV/AIDS Prevention in Central America and Mexico, Quarterly Report April-June 2007 (8/07)
4. Central American Condom Availability in Private Sector High-Risk Outlets Project, Year Two Annual Performance Monitoring Report (October 1, 2006–September 30, 2007 (11/07))
5. Central American Condom Availability in Private Sector High-Risk Outlets Project, Year Three Workplan (October 1, 2007–September 30, 2008 (11/07))

2. ALLIANCES

1. Strategic Alliances for Social Investment USAID Nicaragua/RTI Program, Alliances for Education and Health, Quarterly Report October–December 2007 (1/08)
2. Alliances for Education and Health, status report, undated
3. Annual Report, 2007

3. CAPACITY PROJECT

1. Strengthening HRH to Provide Comprehensive HIV Care and Treatment in Central America, Report Period: October 2006-September 2007
2. *Mejoramiento de Servicios Descentralizados de VIH, Reporte de la Medición Basal del Desempeno, República de Nicaragua*, undated.

4. CENTERS FOR DISEASE CONTROL

1. Actividades que CDC GAP puede apoyar en Nicaragua, FY 2008
2. Sandra Juarez and Edda Marquez, Informe de la Visita Realizada Nicaragua
3. Proyecto de Fortalecimiento de la Vigilancia Epidemiológica de la Coinfección TB/VIH en Nicaragua, 2007. Minuta de Reunion No. 1-07

5. FAMISALUD PROJECT

1. Quarterly Report April-June 2006, *FamiSalud*/USAID
2. Quarterly Report July-December 2006, *FamiSalud*/USAID
3. Quarterly Report January-March 2007, *FamiSalud*/USAID
4. Quarterly Report April-June 2007, *FamiSalud*/USAID
5. Quarterly Report July-September 2007, *FamiSalud*/USAID
6. Quarterly Report October-December 2007, *FamiSalud*/USAID

6. MINISTRY OF HEALTH (MINSA)

1. *Modelo de Atención Integral de Salud (MAIS), MINSA & Sistema Local de atención Integral de Salud (SILAIS)*
2. *Plan Quinquenal*: 2000–2015, *MINSA*
3. *Política de Salud*, *MINSA*
4. *Plan Operacional Anual* (POA), *MINSA*
5. Quarterly and Annual Reports and Plans

7. PSI/PASMO

1. Annual Report FY 2007, October 1, 2006 to September 30, 2007
2. Annual Report January–September 2006
3. Annual Workplan October 2006–September 2007
4. Annual Workplan October 2007–September 2008
5. Quarterly Report, April–June 2007

8. *PRONICASS* (MSH)

1. Final Report Management and Leadership Project of Nicaragua, April 2003–September 2005, undated
2. Quarterly Report October–December 2007 (1/08)
3. Quarterly Report July–September 2007 (10/07)
4. Quarterly Report April–June 2007 (7/07)
5. Quarterly Report January–March (4/07)
6. Quarterly Report July–September 2006 (10/06)
7. Quarterly Report April–June 2006 (7/06)
8. Quarterly Report January–March 2006 (4/06)
9. Annual Operating Plan, Proposed Modifications (7/07)
10. Annual Operating Plan, Proposed Modifications, *MINSA* (2006)

9. QUALITY ASSURANCE PROJECT/HEALTH CARE IMPROVEMENT PROJECT

1. QAP Nicaragua, July-June 2006 Report & July-June 2007 Annual Workplan (8/30/2006)
2. QAP Nicaragua, July 2006-June 2007 Annual Report, Directions for FY 8 (11/07/07),
3. QAP Nicaragua, October 05 to September 06 Annual Report
4. First Year Work Plan, October 07–September 08
5. *Iniciativa de Unidades de Salud Amigas de la Niñez y la Madre en Nicaragua, Factores influyentes para es éxito y sostenibilidad, Octubre 2006*
6. Health Care Improvement Project, undated four-page handout

10. SURVEYS, RESEARCH

1. ENDESA, 2006/7 Reproductive Health Survey
2. Census 2005 Nicaragua
3. Nicaragua Health Situation Analysis, PAHO
4. World Bank, *Informe Borador, "Estudio de las Casas Maternas en Nicaragua*," (10/15/07)

11. TITLE II AND DAP

1. Final Report: Title II, ADRA Nicaragua Fiscal Year 2005 Results Report (11/01/05)
2. Title II Nicaragua/Save the Children USA, Fiscal Year 2005 Results Report (11/22/06)
3. Title II Nicaragua/Catholic Relief Services, CSRA Submission, FY 2005 Results Report (11/1/05)
4. Title II DAP Review and Evaluation Worksheet, FY 2004, Save the Children
5. Final Evaluation, USAID/Nicaragua Title II Development Assistance Programs, 2002-2008, December 2007
6. *Marco Conceptual Modelo de Atención Integral en Salud (MAIS) (12/07*)

12. USAID/NICARAGUA

1. Nicaragua Country Plan, in Support of the Central America and México Regional Strategy, 2003–2008 (8/03)
2. SOAG, Health, 2003–2008
3. Activity Design Document, SO3, IRs 3.1, 3.2, 3.3
4. Annual Report, 2003
5. Annual Report, 2004
6. Annual Report, 2005
7. Annual Report, 2006
8. Performance Report, FY07

13. POWERPOINT PRESENTATIONS

1. CS Jinotega Project–Final Evaluation Present Mayo 2007.ppt
2. *Colaborativo ITS-VHI resumen feb 08.ppt*
3. 10th Censo 2005–presentation.ppt
4. 16. Capacity *MINSA* Presentation Aug 07.ppt
5. *FamSalud3Presen1er Nivel MINSA 5040806.ppt*
6. *NicaSalud* Presentation 2007.final.ppt

ANNEX 3: CONTACTS

USAID/NICARAGUA

Mission Directorate

Alexander Dickie IV, Mission Director
Carol Horning, Deputy Mission Director
Mildred Obregon, Program Officer
Ginger Waddell, Program Officer
Virginia Prudo, Deputy Controller

Office of Human Investment

Connie J. Johnson, Chief
Heather Smith, HIV/AIDS Specialist
Claudia Evans, Reproductive Health Specialist
Emilia Gaitán, Education Specialist
Ivan Tercero, Health Team Leader and MCH Specialist

MINISTRY OF HEALTH (MINSA)

Department of Health Services

Liana Vega Mejía, Director General
Dinora Corea, Health Promotion
Jorge Orochena, Health Promotion
Ariel Salinas, External Relations
Sara Moraga, HIV/AIDS
Celia Valverde, Director of Regulation

MULTILATERAL DONORS

Inter-American Development Bank

Edmundo Quintanilla A, Sector Specialist (Health)

Netherlands Embassy

Maria Jesús Largaespada, Senior Health Expert

Pan American Health Organization (PAHO)

Socorro Gross, PAHO Representative
Alma Fabiola Morales, PAHO Reproductive Health Advisor
Reynaldo Aguilar, PAHO Child Health & HIV/AIDS Advisor

United Nations Children's Fund (UNICEF)

Debora Comini, Representative

Maria Machicado Terá, Deputy Representative
Fátima Ivette Sandino, Health and Nutrition Specialist
Jose Ramon Espinoza, HIV Advisor

United Nations Population Fund

Edgard Navaez D., Reproductive Health Logistics Advisor, UNFPA
Darlene Omier, Reproductive Health Specialist, UNFPA
Carla Aburto, HIV/AIDS Advisor, UNFPA

World Bank

Miriam Montenegro, Human Development Operations Officer

USAID IMPLEMENTING PARTNERS

Adventist Development and Relief Agency (ADRA)

Plinio R. Vergara, Country Director
Cindy Vasquez, Director of Health

Alliances for Education and Health

Frank Matus-Aguirre, Country Director, Alliances, RTI
Manuel A. Roman Lacayo, Country Program Manager, Alliances

Catholic Relief Services

Jose Francisco Mendieta, Health Program Manager, Catholic Relief Services

CARE Nicaragua

Ralph Merriam, Country Representative, CARE, Nicaragua
Ezequiel Provedor, Health Program Coordinator, CARE

Capacity Project

Nestor Gonzalez, Project Manager, Capacity Project, IntraHealth

DELIVER

Carolina Aráuz, Resident Advisor, DELIVER, JSI
Maritza Narváez Flores, Logistics Advisor

Federación Red NicaSalud

Josefina Bonilla Zuniga, Executive Director
Charles Wallace Boudier, FamiSalud Project Coordinator
Nelly Martinica, HIV Coordinator

FamiSalud Project, NicaSalud

Ovidio Blanco, Monitoring and Evaluation Coordinator

Health Care Improvement/Quality Assurance Project, University Research Corporation

Oscar Alberto Nunez, Country Director

Danilo Nuñez Aguirre, HIV Advisor
Ivonne Gómez, Pediatric Care Advisor
Luis M. Urbina Téllez
Indira Moreno R.
Yudi Wong Blandon

Institute for Reproductive Health (IRH), Georgetown University

Ximena Gutiérrez Gómez

Panamerican Social Marketing Organization (PASMO), Population Services International

Donald Moncada S., Country Director
Susana Lungo, Regional Director for Marketing and Technical Services
Eugenia Monterroso, Chief of Party, Abt

Project Concern International (PCI)

Maria Zepeda, Director of Monitoring & Evaluation

Project HOPE, Nicaragua

Silvia Coronado Lopez, Country Director
Pedro Ramirez, Project Coordinator for FamiSalud

PRONICASS

Leadership, Management & Sustainaibility Project, Management Sciences for Health

Barry Smith, Director
Manuel Rodriguez Rojas, Technical Coordinator
Carlos Sáenz Torres, Technical Assistant

Save the Children

Peter LaRous

FIELD VISITS

Chinandega

Maria Estelle Estrada, Director of MCH, SILAIS
Bernadita Molina, Director, Chinandega Maternal & Child Health Hospital
Juan Ramos, Director of Pediatrics, Chinandega Maternal & Child Health Hospital
Evelyn Lara Alvarado, Director, AMOCSA Hospital
William Martinez, Director, Corinto Community Health Center
Ester Martinez, Director of Training, Corinto Community Health Center
Veronica Gomez, Community Health Trainer, Corinto Community Health Center
Nelson Caballero, ADP, FamiSalud Coordinator, Polsotega
Rueda, Epidemiology & Quality Control, Polsotega Municipal Health Department
Salgado, Coordinator, Polsotega Municipal Health Department
Villa de Nueva, ECMAC Promotor, FamiSalud, Polsotega
Santiago Ruedas, ECMAC Promotor, FamiSalud, Polsotega
Celia Vargas, Brigadista, Santa Maria Community, Polsotega
Yader Romero, PASMO Promoter
Arline Alonso, Director of MCH, SILAIS
Manuel Villanueva, Director of Internal Medicine, Hospital España
Eugenia Monterroso, Chief of Party, PASMO
Susana Lungo, Regional Director for Marketing and Technical Services, PASMO

Estelí

Victor O. Triminio, SILAIS Director, Department of Health
Jose Angel Ubeba Mirada, Director, Estelí Hospital
Marcia Gomez, Assistant Director, Estelí Hospital
Nellie Rivera, Director of Pediatrics, Estelí Hospital
Dra. Claudia Garcia Ramos, Director, Pueblo Nuevo Municipal Health Center
Casa Blanca Brigadistas
Auxillary Nurse, Casa Blanca
Gloria, PASMO Promoter

Matagalpa

Denis Gonzalez, Assistant Director, Cesar Amador Molina Regional Hospital
Maria Elsa Ruez, Arco Iris (Rainbow Net) Project Director, Alliances, San Ramon
Leonardo Narvias, Arco Iris (Rainbow Net) Supervisor, Alliances, San Ramon
Ana Maria Membrano, Arco Iris (Rainbow Net), Medical Doctor, Alliances, San Ramon
Maritza Manzanares Duartes, FamiSalud Coordinator, San Ramon

RAAN

Noel Espinosa, Director, Carlos Sentero Health Center, Siuna
Kelvin, Assistant Director, Carlos Sentero Health Center, Siuna

Claudia Guzman, Director of Nursing, Carlos Sentero Health Center, Siuna
Maria Mercedes Morales, Director of Epidemiology, Carlos Sentero Health Center, Siuna
Adayiba Gonzalez, Project Coordinator FUPADE, Alliances

León

Benjamin Barreto, Director, SILAIS
Parajon Argentina, Technical Assistant, PRONICASS
Mariana Guido, Strategic Planning Assistant, PRONICASS
Talita F. Rizo, PRONICASS
Aida Blanco Talavera, Nursing, PRONICASS
Gilberto Moreno Avellan, Director Epidemiology, PRONICASS
Ana Cristian Melendez Darce, Epidemiology, PRONICASS
Dana Forseca, Director of MCH, SILAIS
Ricardo Cuadra, Director, Oscar Danilo Rosales Hospital
Maria Adelia Quesada, Chief High-Risk Obstetrics, Oscar Danilo Rosales Hospital
Lourdes Jose Maria Salon, Chief Labor and Delivery, Oscar Danilo Rosales Hospital
Marta Mercado, Chief of Postpartum, Oscar Danilo Rosales Hospital
Dixmer Rivera, FamiSalud Coordinator, Save the Children Federation

Managua

Maynor, PASMO Promoter
Maryeling Merillo, AulaNet Coordinator, School of Nursing, Polytechnical University

ANNEX 4: KEY MATERNAL & CHILD HEALTH INDICATORS BY SILAIS

1. MATERNAL HEALTH INDICATORS

Characteristic	Percent of Live Births with Professional Attendant (8/2001–9/2006)*	Percent of Deliveries by Cesarean Section (8/2001–9/2006)*	Number of Maternal Deaths**
AREA			
Urban	92.3	27.9	ND
Rural	56.0	11.7	ND
REGION			
Pacific	88.5	28.5	ND
North Central	66.7	12.8	ND
Atlantic	44.8	7.8	ND
DEPARTMENT			
Nueva Segovia	77.0	11.8	5
Jinotega	**45.7**	**13.0**	12
Madriz	**69.3**	**11.2**	0
Esteli	92.8	20.1	2
Chinandega	81.2	19.6	4
Leon	85.6	31.4	6
Matagalpa	**70.3**	**9.4**	16
Boaco	**63.3**	**14.6**	2
Managua	95.2	31.0	8
Masaya	80.6	25.8	4
Chontales	**72.3**	17.9	10
Granada	86.3	31.8	3
Carazo	85.5	31.4	4
Rivas	84.2	24.9	4
Rio San Juan	**59.7**	**12.6**	2
RAAN	**37.9**	**5.0**	15
RAAS	**48.0**	**9.4**	14
SOCIOECONOMIC QUINTILES			
Low	41.8	6.9	
Medium-low	74.1	14.4	
Intermediate	89.1	20.8	
Medium-high	94.9	29.5	
High	98.5	44.1	
TOTAL	**73.7**	**19.6**	**111**

NB: *SILAIS* in bold font indicates that both figures are above the national average (not applicable for crude number of maternal deaths.)
*Source: *ENDESA* Preliminary Report (2/08), Table 9b.
** Source: *MINSA* 2007.

2. NEWBORN HEALTH INDICATORS

Characteristic	Neonatal Mortality Rate per 1,000 Live Births (birth–28 days)	Post-Neonatal Mortality Rate per 1,000 Live Births (1–11.9 months)	Infant Mortality Rate per 1,000 Live Births (0–11.9 months)
AREA			
Urban	14	10	24
Rural	18	16	34
REGION			
Pacific	15	10	26
North Central	14	13	27
Atlantic	22	21	43
SOCIOECONOMIC QUINTILES			
Low	17	18	35
Medium-low	17	17	33
Intermediate	14	11	24
Medium-high	17	8	25
High	13	6	19
TOTAL	**16**	**13**	**29**

Source: *ENDESA* Preliminary Report (2/08), Table 14a.

3. CHILD HEALTH INDICATORS

Characteristic	Total Immunization Rate (Percent of Children 18–29 months)	Chronic Malnutrition (Height for Age; Percent of Children < 5 years)		Acute Respiratory Infection (ARI) (Percent of Children < 5 years with an ARI in the Previous 2 Weeks)	Diarrhea (Percent of Children < 5 years with an Episode of Diarrhea in the Previous 2 Weeks)
		Severe	Total		
AREA					
Urban	88.5	2.6	10.6	28.2	13.2
Rural	81.6	6.0	22.7	29.9	17.6
REGION					
Pacific	88.4	2.3	11.4	ND	ND
North Central	85.6	7.0	24.0	ND	ND
Atlantic	71.6	4.9	18.6	ND	ND
Nueva Segovia	95.7	5.3	20.8	24.5	15.0
Jinotega	81.1	11.6	32.6	40.1	22.3
Madriz	90.6	7.6	29.7	31.9	13.2
Esteli	95.3	1.8	11.0	30.4	9.3
Chinandega	92.2	2.8	16.7	40.4	16.3
Leon	90.8	2.0	10.4	19.7	13.4
Matagalpa	80.7	6.6	26.2	28.5	16.4
Boaco	86.9	2.9	10.9	27.6	19.8
Managua	83.1	2.3	10.6	29.5	14.6
Masaya	92.4	4.0	14.4	27.7	10.2
Chontales	87.2	5.7	13.5	32.8	16.2
Granada	97.3	0.6	8.6	19.6	9.3
Carazo	91.3	2.2	10.0	23.2	7.2
Rivas	92.8	1.1	5.9	20.7	12.1
Rio San Juan	87.8	**5.2**	**17.0**	32.9	17.7
RAAN	59.1	**6.5**	**24.2**	32.5	23.7
RAAS	83.2	**3.1**	**13.1**	18.7	13.6
SOCIOECONOMIC QUINTILES					
Low	77.8	8.2	28.0	31.3	20.0
Medium-low	88.0	3.6	18.5	30.1	14.2
Intermediate	88.1	3.7	13.6	33.3	17.6
Medium-high	88.0	1.6	7.5	27.6	12.4
High	88.7	0.8	4.5	18.0	7.8
TOTAL	**85**	**4.3**	**16.9**	**29.1**	**15.5**

NB: *SILAIS* in bold font indicates both malnutrition rates are above the national average. (Not applicable for other three indicators.)
Sources: *ENDESA* Preliminary Report (2/08), Tables 12, 11, 11, 13 and 13.

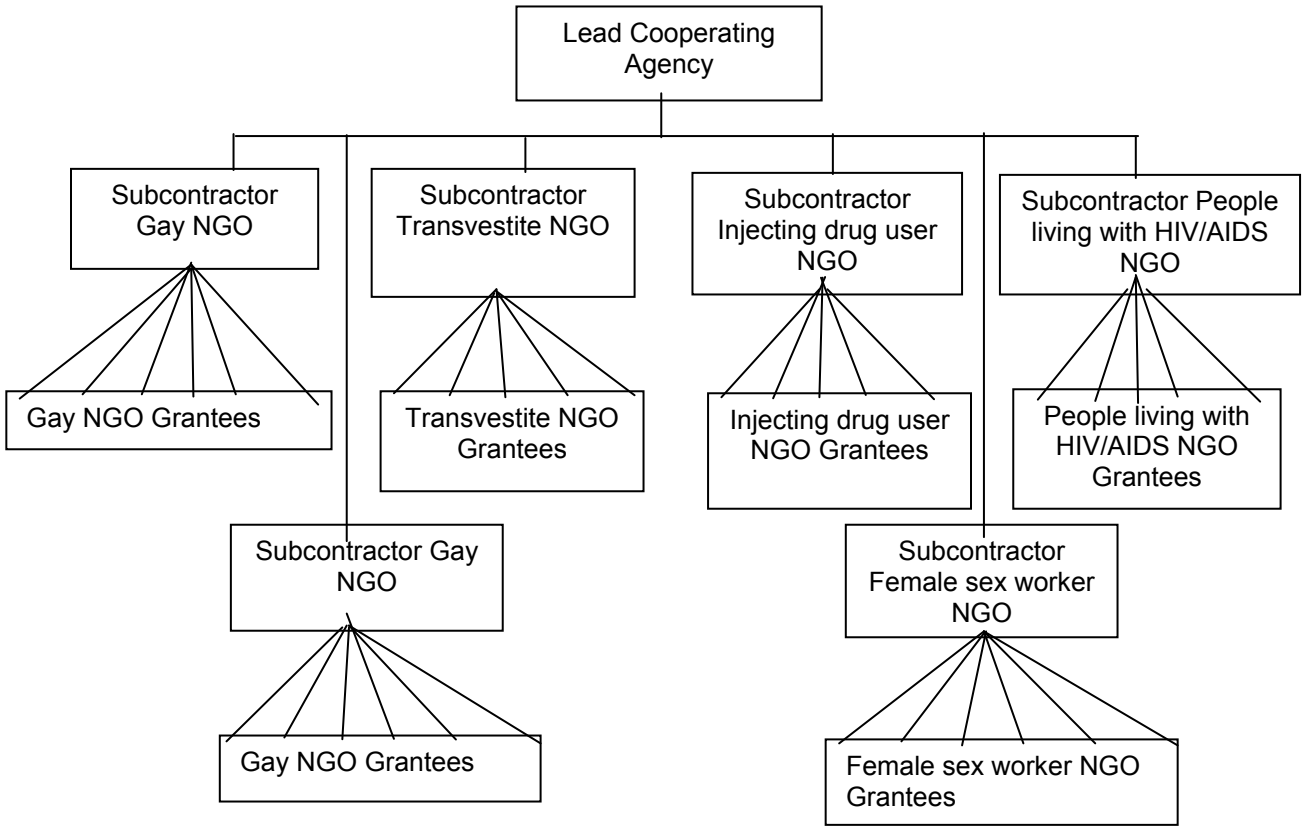
E. MATERNAL HEALTH, CHILD HEALTH AND HIV/AIDS ACTIVITIES BY PROJECT

Activity	FamiSalud	HCI	Alliances	PRONICASS	PASMO
Nutrition					
Growth promotion and monitoring	X		X		
Early detection of childhood diseases and referral	X		X		
Early child stimulation health	X				
Nutrition counseling	X		X		
Micronutrients (Vit A, Fe++, Zn)	X				
Maternal Health					
Birth plan at community level (early detection of danger signs, referral)	X				
Prenatal care	X	X			
Essential obstetric care		X			
Postpartum care	X	X			
Cultural adaptation of delivery care	X	X			
Private sector care		X	X		
Pre-service		X	X		
Child Health					
Case management of severely ill children < 5 years	X	X			
Clinical training centers (hospitals)		X			
Inservice education for hospital providers (RN & MD)		X	X		
Private sector care		X			
Preservice		X	X		
MCH Cross-cutting Activities					
Health education at community level	X		X		
Avian Influenza Communication Campaign	X		X		
Quality improvement	X	X			
Health Systems Strengthening					
Results-based budgeting and planning				X	
Norms of service delivery processes				X	
Decentralized human resource management				X	
Institutional capacity building		X		X	
Basic package of services				X	
Management of social sector services				X	
Integration of Pharmaceutical Logistics System				X	
Nonprofit drug outlets	X				
HIV/AIDS					
	FamiSalud	**HCI**	**Capacity**	**PRONICASS**	**PASMO**
Behavior change communication (BCC)					X
Voluntary Testing & Counseling (VCT)		X			X
Sexually-transmitted Infections (STI)		X			X
Research, surveillance			X		X
Supplies, medications, logistics					
Systems strengthening		X		X	
PMTCT					
High-risk populations					X

ANNEX 5: BRAZILIAN NGO MODEL AND FUNDING MECHANISMS TO REDUCE MANAGEMENT BURDEN[16]

The following notes are extracted from two strategic plans, one in Brazil and the other in Honduras. The Brazilian model demonstrates how consortia of NGOs could be organized to increase coverage without incurring significant management costs. The model called for six principal subcontractors, one for each target group. In Nicaragua, this would be reduced to three (highlighted). The description follows.

Figure 2: Proposed NGO Structure



NGO activities. An RFA for an umbrella NGO from Brazil or the U.S. with approximately 6 local subcontractor NGOs that represent or work with gays, transvestites, female sex workers, injecting drug users, and/or people living with HIV/AIDS, and which (ideally) have one or more "best practices" that could be easily replicated in other sites. Each of these subcontracted NGOs would, in turn, fund smaller NGOs that work with one or more of these high-prevalence groups in the targeted geographic areas. The objective would be for each of the larger local NGOs to identify, strengthen, and fund approximately 10 small NGOs each in the first year (ranging from 6 to 15, depending on the size of the target population and the number of NGOs specializing in or

16 Reynolds, Jack, et. al., Brazil HIV/AIDS Strategic Plan, 2003-2008, The Synergy Project/TvT Associates, February, 2003.

representing that group), adding an additional 10 NGOs for each of the following four years, for a total of 240 NGOs by the end of the fourth year. See Figure 2: Proposed NGO Structure.

An alternative to an RFA would be a buy-in to a new USAID funding mechanism specifically designed to make it easier for Missions to fund small NGOs with little management burden. It is called the Community REACH project. It could be organized the same way but it would not require the Mission to compete the work or to manage the large numbers of small NGOs that this strategy suggests. REACH will provide the Mission with more information about this mechanism.

A single consortium procurement. The principal advantage of this arrangement is that it reduces management burden to one agreement. The prime is responsible for monitoring and supervising the subcontractors. The disadvantage is the potential for a lower level of expertise, as well as a loss of control over the subcontractors in particular.

The design team would recommend that the lead cooperating agency (CA) be a US-based technical assistance agency with a proven management track record and expertise in NGO support. This is probably the area that will require the most technical assistance and support. The two major subcontractors (for surveillance and social marketing) would preferably be Brazilian entities, or at least semi-autonomous branches of a US-based organization that would be staffed by Brazilians. The lead CA, which would be responsible for the NGOs, might subcontract with 3–4 strong Brazilian NGOs that work with the four high-prevalence populations. They in turn would identify, strengthen, and supervise local NGOs as described above.

Options to reduce management burden[17]

This segment is taken from the Honduras Strategic Plan. It is followed by a description of the Community REACH project, which is discussed above.

One of the major concerns that the Mission has about this strategy is the "management burden," or the amount of work it will require of Mission personnel. This is a legitimate concern, especially since the Mission is downsizing. However, the Mission has a number of management options, some of which could actually reduce the overall management burden. A few of these options are described briefly in the following paragraphs.

- **Buy-ins to central projects**. The Mission could expand its ongoing transfer of funds to USAID/Washington to procure the services of an existing, centrally funded CA that would carry out the needed work. This would transfer most of the management burden to USAID/W.
- **Performance grants to regions (and, possibly, NGOs)**. This type of contract/agreement/grant would reduce management burden significantly. It has been implemented successfully in the Philippines, Uganda and other countries. USAID/Honduras has already signed an agreement with AED as an umbrella agency for sub-grants to Honduran NGOs working in AIDS. This process could be further expanded in selected regions, in which USAID could contract an organization to process, select, and manage the funds of the program or project. That organization would manage all sub-contracts and would be paid on the basis of overall performance, which would be measured by annual outcome indicators. There would be no day-to-day supervision, monthly or quarterly vouchers or other management requirements. The Mission would only need to collect data on performance and make payments accordingly.

17 Reynolds, Jack, et. al., Honduras HIV/AIDS Strategic Plan, 2003-2008, The Synergy Project/TvT Associates, October 2002

- **Develop an RFA to manage the regional activities.** An RFA could be developed to select a qualified organization to provide technical and management assistance to the three health regions (San Pedro Sula, La Ceiba and Metropolitana) and the national level (MOH). The awardee would set up a project management unit to provide technical assistance and to manage the funds. This would give the Mission four management units, one each for the MOH, NGOs, social marketing, and the regions. The first three are currently in operation, so this option would only require one additional CA.
- **Hire expert advisors through personal services contracts.** This is one way to augment the Mission staff. The Mission has already hired a CDC technical advisor in AIDS and Child Survival (TAACS). It could also use program funds to hire individual advisors and/or staff for project implementation units. Since these individuals would be hired by the Mission, they would be expected to take on project supervision responsibilities and would act as extensions of the Mission.

ANNEX 6: DAPS TITLE II PROJECTS—EXECUTIVE SUMMARY

Four U.S. Private Voluntary Organizations were awarded PL 480 Title II grants for implementing their Development Assistance Programs during the period FY 2002 through FY 2008 to improve the food security conditions in selected northern communities. The implementers, called Cooperating Sponsors (CSes), are Catholic Relief Services (CRS), Project Concern International (PCI), Adventist Development and Relief Agency (ADRA), and Save the Children USA (SCF).

The program results to date can be summarized as generally successful in reaching the targets of increased productivity and profitability in agriculture, increased income generation in off-farm activities, diversified diets and improved nutrition for all participating families, improved availability of potable water and sanitary conditions, and reduction in the prevalence of malnutrition in young children.

Over 63,000 mothers have learned to track the weight gains of their young children and administer more nutritious diets during early childhood. Education programs for better health practices, care for diarrheal disease and acute respiratory infection, safe motherhood, and adoption of the "Community Health and Nutrition Program" are ongoing. Hundreds of village health volunteers have been trained to assist and advise them, with the support of the Ministry of Health (MINSA). Potable water and latrine installations have made major contributions to village hygiene and general health within selected communities.

In health, water, sanitation, and small-scale agriculture, the project has made visible and positive impacts that can endure as long as beneficiaries continue to practice what they have learned.

Combined participation reported by the Cooperating Sponsors total 257,379 beneficiaries to date. Following is a brief discussion of the accomplishments in each sector by each of the Cooperating Sponsors.

IMPROVED HEALTH AND NUTRITION OF WOMEN AND CHILDREN

The health and nutrition activities under this project have emphasized weight gain monitoring and counseling, improved nutrition, and distribution of wet and dry rations to mothers of young children and pregnant women. These strategies have been responsible for nearly or completely surpassing target reductions in the incidences of underweight children in selected communities in the northern parts of the country.

The PCI health program component reached 12,904 beneficiaries (pregnant and lactating mothers, children under two years old) in 300 communities by training 454 village health volunteers, monitoring the health of young children and pregnant women, providing guidance on their health care, promoting better nutrition, and developing community birth plans. PCI helped introduce the 'Safe Motherhood' program in 14 communities and its success is leading to further expansion. Malnutrition was reduced 35% to a current prevalence of 14.6% among the targeted 10,194 children under two years old.

CRS has been educating parents on health issues relating to young children, distributing food, monitoring weight gain among children, providing guidance on health care and training community health volunteers. Its program has reached 2,865 males and 10,933 females, while providing support to 290 volunteers. Training has featured nutrition, prevention of diarrheal and respiratory diseases and promotion of breastfeeding. Overall, chronic malnutrition appears to have stabilized, as CRS has been recently more focused on municipalities with more severe

problems. Exclusive breastfeeding adoption, at 80% in the target communities for infants under six months old, is a significant increase over the baseline and far above the national rate. A disaster preparedness planning exercise was carried out in 30 communities.

ADRA's health programs have reached 70,031 beneficiaries in 154 rural communities, counting all participating mothers and children. In addition to its feeding and health monitoring for small children and pregnant women, ADRA's social medicine outposts in rural communities have brought affordable medicines to hitherto uncovered locations on a sustainable basis. The establishment of 'Base Houses' was a new feature under the ADRA program, where community health activities are now concentrated. This approach contributed to the reduction of chronically malnourished children under two years old, down from 46% in FY 2002 to 12% in FY 2007.

SCF reached 23,824 health beneficiaries, or 232% of the planned life-of-activity target. These included 13,210 mothers and 10,614 children. (Many of these mothers are counted in other participation categories rather than under Health in the Beneficiaries Section V D.) SCF concentrates community health activities at 'Community Children's Centers' and great improvements in reducing chronic malnutrition of children under two years old was achieved, from 22% in FY 2002 to 10% in FY 2007. In addition to food distribution, weight gain monitoring, and training of mothers for improved infant nutrition, SCF's health component also focused on early childhood learning through regular interactive play and stimulation.

IMPROVED SANITARY CONDITIONS

The water and sanitation component of the project has targeted the lack of potable water and hygienic facilities in rural communities. The measures taken include well excavation, pump installation, aqueduct construction, distribution network installations, forming of community water management committees, latrine construction, and education on water- and hygiene-related health topics.

PCI's program constructed or rehabilitated 27 potable water systems, serving roughly 10,500 users in the Department of Jinotega, and participated in the building of latrines serving 1,194 households (6,567 beneficiaries). Since Jinotega is mountainous country, 21 of the potable water systems rely on gravity flow. Five wells were dug and one electric-powered borehole pump was installed. Community water committees were formed and assistance with management training was an important component, as were the establishment of user fee and maintenance systems.

ADRA has constructed 78 small potable water systems in Nueva Segovia and Madriz, of which most are wells with rope-and-washer pumps. They serve approximately 6,800 users. ADRA also assisted in the construction of latrines for 1,000 families. Community trash clean-up and garbage management was a precondition for participation.

ANNEX 7: SUMMARY OF CHILD SURVIVAL PROJECTS

CARE

The Childhood Survival Project was a second phase of the project implemented during the 1998-2002 period in the municipality of Matagalpa. It began in October 2002 and ended in September 2007, and continues to cover the Matagalpa municipality as well as to include the La Dalia and Waslala municipalities located within the Matagalpa Department.

CARE was implementing this Project in conjunction with the Ministry of Health of

Matagalpa which is the principal partner and with a local NGO, IXCHEN, that

implements the Maternal – Child Health Service Provider Model.

The objective was to contribute to a reduction in maternal – child mortality and morbidity of 15% in the Matagalpa Department, specifically in the Matagalpa, La Dalia and Waslala municipalities, for the year 2007.

The objectives of the project were:

1. Improve access to and quality of maternal and child health (MCH) services in the public and private sectors in Matagalpa.

2. Improve access to and quality of maternal and neonatal health services in thehospital in Matagalpa.

3. Strengthen household decision-making resulting in the practice of healthy behaviors. The components of the Project include: Maternal/Newborn Care (50%), Nutrition (30%), Management of Pneumonia Cases (10%), and Control of Diarrhea-Related Illnesses (10%). The cross-cutting approaches include: (a) strengthening capacity, (b) community mobilization, (c) behavior change communication chain, and (d) quality assurance. In addition, work is being conducted to strengthen the municipal health committees in the three municipalities.

The beneficiary population was 58,052 women of reproductive age, 60,150 children under 5 years of age, and 56,165 newborns. It also includes 21 primary health care units and 173 communities that were organized into health networks surrounding each health post during the first phase.

ADRA

The Child Survival XVII Program entitled “Healthy Children in Healthy Communities” was implemented by the Adventist Development and Relief Agency (ADRA. The program was located in the department of Madriz, along the border with Honduras in the northern region of Las Segovias. The project area covered six of the nine municipalities of Madriz Department: Cusmapa, Las Sabanas, San Lucas, Palacagüina, Yalagüina and Totogalpa. Direct beneficiaries included 10,212 children under five years old (3,486 of whom were under two years old in 2000) and 31,965 women of child-bearing ages, for a total of 66,044 direct beneficiaries.

Goal: The program goal was “To improve the quality of life in Madriz, reducing morbidity and mortality among children and mothers, promoting the right to health for mothers and children,

improving the population's level of health education, and strengthening community organization and inter-institutional coordination."

Strategic Objectives:

Objective 1: *To improve the quality of care in health units.* This objective was completed by implementing the strategies of: increasing knowledge and applying Standard Case Management protocols among health workers; developing closer contacts between health post / center personnel and communities; and promoting competition.

Objective 2: *To improve the adoption of good health habits in the communities.* Basic strategies were founded on prior ADRA efforts in Madriz: reinforcing or maintaining the adoption of good habits; re-motivating those who, for different reasons, had discontinued the practice of good health habits; reducing obstacles against the adoption of good health habits; and establishing mechanisms to identify and support actions within the local social and health systems that can reinforce positive health behaviors in the communities.

Objective 3: *To improve access to healthcare.* To meet this objective, the basic strategies involved: establishing 24-hour emergency obstetric services wherever possible; helping communities to establish pharmacies or Social Medicine Outposts (SMOs); and organizing and maintaining the operations of Base Houses.

PROJECT HOPE

Project HOPE has been implementing a five-year Jinotega Child Survival Project (JCSP since 2002, aimed at improving the health status of children under five and women of reproductive age in the Department of Jinotega, Nicaragua. The focus has been on rural populations, including those working on coffee plantations. The main partners in implementation were the Ministry of Health (MOH) at the Departmental level (SILAIS), Health Centers/Posts, and private sector coffee growers.

Specific program health interventions and level of effort included the following: maternal and newborn care (30%), nutrition/micronutrient deficiencies (13%), breastfeeding promotion (10%), control of diarrheal disease (15%), pneumonia case management (10%), immunization (7%), child spacing (10%), and HIV/AIDS/STIs (5%). The proposed interventions focused on the MOH's PROCOSAN initiative, which is a program based on community growth monitoring. This initiative incorporates IMCI, community-based family planning, Life Saving Skills training, Birth Plan for health facility staff and community health volunteers, and strengthening the Health systems and quality of care.

The project focus was to strengthen the SILAIS and all health units within the department. The target population was identified as the entire population of Jinotega, totaling 62,451 children under five and 67,461 women of reproductive age living in approximately 750 villages (129,912 total beneficiaries). All MOH health facility staff has been involved in institutional strengthening activities, but the CSP selected 80 priority communities where the project would provide more direct support to community based activities on a monthly basis.

For more information, please visit
http://www.ghtechproject.com/resources/

Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
www.ghtechproject.com